By: Hancock S.B. No. 1153

(In the Senate - Filed February 26, 2019; March 7, 2019, read first time and referred to Committee on Business & Commerce; March 27, 2019, reported favorably by the following vote: Yeas 8, Nays 0; March 27, 2019, sent to printer.)

COMMITTEE VOTE

	Yea	Nay	Absent	PNV
Hancock	X			
Nichols	X			
Campbell	X			
Creighton	X			
Menéndez			X	
Paxton	X			
Schwertner	X			
Whitmire	X			
Zaffirini	X			

A BILL TO BE ENTITLED
AN ACT

relating to the Texas Life and Health Insurance Guaranty Association.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 463.002, Insurance Code, is amended to read as follows:

Sec. 463.002. PURPOSE. The purpose of this chapter is to protect, subject to certain limitations, a person specified by Section 463.201 against failure in the performance of a contractual obligation under a life, accident, [~~or~~] health, [~~insurance policy~~] or annuity policy, plan, or contract with respect to which this chapter provides coverage as determined under Subchapter E, because of the impairment or insolvency of the member insurer that issued the policy, plan, or contract.

SECTION 2. Section 463.003, Insurance Code, is amended by amending Subdivisions (4), (7-a), and (9) and adding Subdivisions (4-a), (4-b), (5-a), and (6-a) to read as follows:

(4) "Covered policy" or "covered contract" means a policy or contract, or portion of a policy or contract, including a health maintenance organization contract, with respect to which this chapter provides coverage as determined under Subchapter E.

(4-a) "Enrollee" means an individual who is enrolled in a health maintenance organization contract with respect to which this chapter provides coverage as determined under Subchapter E. For purposes of this chapter, an enrollee is considered to be an insured.

(4-b) "Health benefit plan" means a hospital and medical expense incurred policy or certificate, health maintenance organization enrollee contract, or any other similar health contract. The term does not include:

(A) accident-only insurance;

(B) credit insurance;

(C) dental-only insurance;

(D) vision-only insurance;

(E) Medicare supplement insurance;

(F) long-term care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;

(G) disability income insurance;

(H) coverage for on-site medical clinics; or

(I) specified disease, hospital confinement indemnity, or limited benefit health insurance coverage if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates.

2-1 (5-a) "Insurance" includes health benefit plan
2-2 coverage.
2-3 (6-a) "Insurer" includes a health maintenance
2-4 organization.
2-5 (7-a) "Owner" means the owner of a policy or contract
2-6 and "policyholder," "policy owner," and "contract owner" mean the
2-7 person who is identified as the legal owner under the terms of the
2-8 policy or contract or who is otherwise vested with legal title to
2-9 the policy or contract through a valid assignment completed in
2-10 accordance with the terms of the policy or contract and is properly
2-11 recorded as the owner on the books of the member insurer. The terms
2-12 "owner," "contract owner," "policyholder," and "policy owner" do
2-13 not include persons with a mere beneficial interest in a policy or
2-14 contract.
2-15 (9) "Premium" means an amount received on a covered
2-16 policy, less any premium, consideration, or deposit returned on the
2-17 policy, and any dividend or experience credit on the policy. The
2-18 term does not include:
2-19 (A) an amount received for a policy or contract
2-20 or part of a policy or contract for which coverage is not provided
2-21 under Section 463.202, except that assessable premiums may not be
2-22 reduced because of:
2-23 (i) an interest limitation provided by
2-24 Section 463.203(b)(3); or
2-25 (ii) a limitation provided by Section
2-26 463.204 with respect to a single individual, participant,
2-27 annuitant, or policy or contract owner;
2-28 (B) premiums in excess of $5 million on an
2-29 unallocated annuity contract not issued under a governmental
2-30 benefit plan established under Section 401, 403(b), or 457,
2-31 Internal Revenue Code of 1986;
2-32 (C) premiums received from the state treasury or
2-33 the United States treasury for insurance for which this state or the
2-34 United States contracts to:
2-35 (i) provide welfare benefits to designated
2-36 welfare recipients; or
2-37 (ii) implement:
2-38 (a) Title 2, Health and Safety Code;
2-39 (b) Title 2, Human Resources Code; [,]
2-40 or
2-41 (c) the Social Security Act (42 U.S.C.
2-42 Section 301 et seq.); or
2-43 (D) premiums in excess of $5 million with respect
2-44 to multiple nongroup policies of life insurance owned by one owner,
2-45 regardless of whether the policy owner is an individual, firm,
2-46 corporation, or other person and regardless of whether the persons
2-47 insured are officers, managers, employees, or other persons,
2-48 regardless of the number of policies or contracts held by the owner.
2-49 SECTION 3. Subchapter A, Chapter 463, Insurance Code, is
2-50 amended by adding Sections 463.0032 and 463.007 to read as follows:
2-51 Sec. 463.0032. USE OF TERMS POLICY AND CONTRACT. For
2-52 purposes of this chapter, "policy" and "contract" have the same
2-53 meaning.
2-54 Sec. 463.007. CONSTRUCTION OF LONG-TERM CARE RIDER. For
2-55 purposes of this chapter, benefits provided by a long-term care
2-56 rider to a life insurance policy or annuity contract are considered
2-57 to be the same type of benefits as the base life insurance policy or
2-58 annuity contract.
2-59 SECTION 4. Section 463.052, Insurance Code, is amended to
2-60 read as follows:
2-61 Sec. 463.052. REQUIRED PARTICIPATION IN ASSOCIATION.
2-62 (a) As a condition of engaging in the business of insurance in this
2-63 state, an insurer, including a mutual assessment company, a local
2-64 mutual aid association, a statewide mutual assessment company,
2-65 [and] a stipulated premium company, and a health maintenance
2-66 organization authorized to engage in business in this state, shall
2-67 participate as a member of the association if the insurer holds a
2-68 certificate of authority to engage in a kind of insurance business
2-69 in this state with respect to which this chapter provides coverage

as determined under Subchapter E. The requirement to participate applies regardless of whether the insurer's certificate of authority in this state is suspended, revoked, not renewed, or voluntarily withdrawn.

(b) The following do not participate as member insurers:

(1) [a health maintenance organization;

[(2)] a fraternal benefit society;

(2) [(3)] a mandatory state pooling plan;

(3) [(4)] a reciprocal or interinsurance exchange;

(4) [(5)] an organization which has a certificate of authority or license limited to the issuance of charitable gift annuities, as defined by this code or rules adopted by the commissioner; and

(5) [(6)] an entity similar to an entity described by Subdivision (1), (2), (3), or (4)[, or (5)].

SECTION 5. Section 463.053, Insurance Code, is amended by adding Subsection (c-1) to read as follows:

(c-1) The commissioner shall consider, among other things, whether the directors appointed under Subsections (b) and (c) fairly represent the member insurers that are health maintenance organizations and life, health, and annuity insurers.

SECTION 6. Sections 463.059(a), (c), and (f), Insurance Code, are amended to read as follows:

(a) Notwithstanding Chapter 551, Government Code, or any other law, the board or a committee of the board may meet by telephone conference call, videoconference, or other similar telecommunication method [if immediate action is required and convening a quorum of the board or committee of the board at a single location is not reasonable or practical. A board or committee member who is unable to attend a meeting in person and who is participating in a board or committee meeting by telephone conference call, videoconference, or other similar telecommunication method may be counted to establish a quorum and may vote]. The board may use telephone conference call, videoconference, or other similar telecommunication method for establishing a quorum, voting, or any other meeting purpose in accordance with this section regardless of the subject matter discussed or considered by the board at the meeting.

(c) The notice of a meeting authorized by this section must specify [that] the location of the meeting [is the location at which meetings of the board and committees of the board are usually held].

(f) An audio or digital recording of a meeting authorized by this section must be made in accordance with the association's bylaws. The recording of the open portion of the meeting must be posted on the association's Internet website [made available to the public].

SECTION 7. Section 463.101(a), Insurance Code, is amended to read as follows:

(a) The association may:

(1) enter into contracts as necessary or proper to carry out this chapter and the purposes of this chapter;

(2) sue or be sued, including taking:

(A) necessary or proper legal action to:

(i) recover an unpaid assessment under Subchapter D; or

(ii) settle a claim or potential claim against the association; or

(B) necessary legal action to avoid payment of an improper claim;

(3) borrow money to effect the purposes of this chapter;

(4) exercise, for the purposes of this chapter and to the extent approved by the commissioner, the powers of a domestic life, accident, or health insurance company, a health maintenance organization, or a group hospital service corporation, except that the association may not issue an insurance policy or annuity contract other than to perform the association's obligations under this chapter;

(5) unless prohibited by other law, implement or file

4-1 for an actuarially justified rate or premium increase in accordance
4-2 with the terms and conditions of a covered policy or contract;
4-3 (6) to further the association's purposes, exercise
4-4 the association's powers, and perform the association's duties,
4-5 join an organization of one or more state associations that have
4-6 similar purposes;
4-7 (7) [(6)] request information from a person seeking
4-8 coverage from the association in determining its obligations under
4-9 this chapter with respect to the person, and the person shall
4-10 promptly comply with the request; and
4-11 (8) [(7)] take any other necessary or appropriate
4-12 action to discharge the association's duties and obligations under
4-13 this chapter or to exercise the association's powers under this
4-14 chapter.
4-15 SECTION 8. Section 463.102(b), Insurance Code, is amended
4-16 to read as follows:
4-17 (b) The association may amend the plan of operation. An
4-18 amendment must be approved by the commissioner and takes effect on:
4-19 (1) the date the commissioner approves the amendment;
4-20 or
4-21 (2) the 60th [30th] day after the date the amendment is
4-22 submitted to the commissioner for approval, if the commissioner
4-23 does not approve or disapprove the amendment before the 60th [30th]
4-24 day.
4-25 SECTION 9. Section 463.109, Insurance Code, is amended to
4-26 read as follows:
4-27 Sec. 463.109. ASSOCIATION APPEARANCE BEFORE COURT;
4-28 INTERVENTION. (a) The association may appear before a court in
4-29 this state with jurisdiction over an impaired or insolvent insurer
4-30 concerning which the association is or may become obligated under
4-31 this chapter. The association's right to appear applies to:
4-32 (1) a proposal for reinsuring, reissuing, modifying,
4-33 or guaranteeing the insurer's policies or contracts;
4-34 (2) the determination of the insurer's policies or
4-35 contracts and contractual obligations; and
4-36 (3) any other matter germane to the association's
4-37 powers and duties.
4-38 (b) The association may appear or intervene before a court
4-39 in another state with jurisdiction over:
4-40 (1) an impaired or insolvent insurer concerning which
4-41 the association is or may become obligated; or
4-42 (2) a third party against whom the association may
4-43 have rights through subrogation of the insurer's policyholders or
4-44 enrollees.
4-45 SECTION 10. Sections 463.114(c), (d), and (e), Insurance
4-46 Code, are amended to read as follows:
4-47 (c) At the expiration of the 60th day after approval of the
4-48 document, a member [an] insurer may not deliver a policy or contract
4-49 with respect to which this chapter provides coverage as determined
4-50 under Subchapter E to a policy, [or] contract, or certificate
4-51 holder or enrollee before a copy of the summary document is
4-52 delivered to the policy, [or] contract, or certificate holder or
4-53 enrollee. The document must also be available on request of a
4-54 policy, contract, or certificate holder or enrollee
4-55 [policyholder].
4-56 (d) The distribution, delivery, content, or interpretation
4-57 of a summary document does not guarantee that a policy or contract
4-58 or a policy, [or] contract, or certificate holder or enrollee is
4-59 provided coverage by this chapter if a member insurer becomes
4-60 impaired or insolvent. Failure to receive the document does not
4-61 give an insured or policy, contract, or certificate holder or
4-62 enrollee any rights greater than those provided by this chapter.
4-63 (e) An insurer or agent may not deliver a policy or contract
4-64 described by Section 463.202 that is excluded from the coverage
4-65 provided by this chapter by Section 463.203 unless the insurer or
4-66 agent, either before or in conjunction with delivery, gives the
4-67 policy, [or] contract, or certificate holder or enrollee a separate
4-68 written notice clearly and conspicuously disclosing that the policy
4-69 or contract is not covered by the association.

5-1 SECTION 11. Section 463.153, Insurance Code, is amended by
5-2 amending Subsections (b) and (c) and adding Subsection (b-1) to
5-3 read as follows:
5-4 (b) Class B assessments on [against] a member insurer for
5-5 each account under Section 463.105 shall be authorized and called
5-6 in the proportion that the premiums received on business in this
5-7 state by the member insurer on policies or contracts covered by each
5-8 account for the three most recent calendar years for which
5-9 information is available preceding the year in which the impaired
5-10 or insolvent member insurer became impaired or insolvent bear to
5-11 premiums received on business in this state for those calendar
5-12 years by all assessed member insurers. Except for assessments
5-13 related to long-term care insurance as described by Subsection
5-14 (b-1), the [The] amount of a Class B assessment shall be allocated
5-15 among the separate accounts in accordance with an allocation
5-16 formula that may be based on:
5-17 (1) the premiums or reserves of the impaired or
5-18 insolvent insurer; or
5-19 (2) any other standard deemed by the board in the
5-20 board's sole discretion as being fair and reasonable under the
5-21 circumstances.
5-22 (b-1) The amount of a Class B assessment for long-term care
5-23 insurance written by an impaired or insolvent member insurer shall
5-24 be allocated according to a methodology included in the plan of
5-25 operation and approved by the commissioner. The methodology must
5-26 provide for 50 percent of the assessment to be allocated to accident
5-27 and health member insurers and 50 percent to be allocated to life
5-28 and annuity member insurers. This subsection does not apply to a
5-29 rider to a member insurer's life insurance policy or annuity
5-30 contract that provides long-term care benefits.
5-31 (c) The total amount of assessments on a member insurer for
5-32 each account under Section 463.105 may not in one calendar year
5-33 exceed two percent of the insurer's average annual premiums on the
5-34 policies covered by the account during the three calendar years
5-35 preceding the year in which the impaired or insolvent member
5-36 insurer became an impaired or insolvent insurer. If two or more
5-37 assessments are authorized in a calendar year with respect to
5-38 member insurers that become impaired or insolvent in different
5-39 calendar years, the average annual premiums for purposes of the
5-40 aggregate assessment percentage limitation described by this
5-41 subsection shall be equal to the higher of the three-year average
5-42 annual premiums for the applicable subaccount or account as
5-43 computed in accordance with this section. If the maximum
5-44 assessment and the other assets of the association do not provide in
5-45 a year an amount sufficient to carry out the association's
5-46 responsibilities, the association shall make necessary additional
5-47 assessments as soon as this chapter permits.
5-48 SECTION 12. Sections 463.154 and 463.201, Insurance Code,
5-49 are amended to read as follows:
5-50 Sec. 463.154. DEFERMENT. The association may wholly or
5-51 partly defer an assessment on [of] a member insurer if the
5-52 association believes payment of the assessment would endanger the
5-53 ability of the insurer to fulfill the insurer's contractual
5-54 obligations. The amount of the assessment that is deferred may be
5-55 assessed against the other member insurers in a manner consistent
5-56 with this subchapter.
5-57 Sec. 463.201. PERSONS [INSUREDS] COVERED. (a) Subject to
5-58 Subsections (b) and (c), this chapter provides coverage for a
5-59 policy or contract described by Section 463.202 to a person who is:
5-60 (1) a person, other than a certificate holder under a
5-61 group policy or contract who is not a resident, who is a
5-62 beneficiary, assignee, or payee, including a health care provider
5-63 who renders services covered under a health insurance policy or
5-64 certificate, of a person described by Subdivision (2);
5-65 (2) a person who is an owner of or certificate holder
5-66 or enrollee under a policy or contract specified by Section
5-67 463.202, other than an unallocated annuity contract or structured
5-68 settlement annuity, and who is:
5-69 (A) a resident; or

6-1 (B) not a resident, but only under all of the
6-2 following conditions:
6-3 (i) the member insurers that issued the
6-4 policies or contracts are domiciled in this state;
6-5 (ii) the state in which the person resides
6-6 has an association similar to the association; and
6-7 (iii) the person is not eligible for
6-8 coverage by an association in any other state because the insurer or
6-9 health maintenance organization was not licensed in the state at
6-10 the time specified in that state's guaranty association law;
6-11 (3) a person who is the owner of an unallocated annuity
6-12 contract issued to or in connection with:
6-13 (A) a benefit plan whose plan sponsor has the
6-14 sponsor's principal place of business in this state; or
6-15 (B) a government lottery, if the owner is a
6-16 resident; or
6-17 (4) a person who is the payee under a structured
6-18 settlement annuity, or beneficiary of the payee if the payee is
6-19 deceased, if:
6-20 (A) the payee is a resident, regardless of where
6-21 the contract owner resides;
6-22 (B) the payee is not a resident, the contract
6-23 owner of the structured settlement annuity is a resident, and the
6-24 payee is not eligible for coverage by the association in the state
6-25 in which the payee resides; or
6-26 (C) the payee and the contract owner are not
6-27 residents, the insurer that issued the structured settlement
6-28 annuity is domiciled in this state, the state in which the contract
6-29 owner resides has an association similar to the association, and
6-30 neither the payee or, if applicable, the payee's beneficiary, nor
6-31 the contract owner is eligible for coverage by the association in
6-32 the state in which the payee or contract owner resides.
6-33 (b) This chapter does not provide coverage to:
6-34 (1) a person who is a payee or the beneficiary of a
6-35 payee with respect to a contract the owner of which is a resident of
6-36 this state, if the payee or the payee's beneficiary is afforded any
6-37 coverage by the association of another state; [~~or~~]
6-38 (2) a person otherwise described by Subsection (a)(3),
6-39 if any coverage is provided by the association of another state to
6-40 that person; or
6-41 (3) a person who acquires rights to receive payments
6-42 through a structured settlement factoring transaction as defined by
6-43 Section 5891(c)(3)(A), Internal Revenue Code of 1986 (26 U.S.C.
6-44 Section 5891(c)(3)(A)), regardless of whether the transaction
6-45 occurred before, on, or after the date that section became
6-46 effective.
6-47 (c) This chapter is intended to provide coverage to persons
6-48 who are residents of this state, and in those limited circumstances
6-49 as described in this chapter, to nonresidents. In order to avoid
6-50 duplicate coverage, if a person who would otherwise receive
6-51 coverage under this chapter is provided coverage under the laws of
6-52 any other state, the person may not be provided coverage under this
6-53 chapter. In determining the application of the provisions of this
6-54 subsection in situations in which a person could be covered by the
6-55 association of more than one state, whether as an owner, payee,
6-56 enrollee, beneficiary, or assignee, this chapter shall be construed
6-57 in conjunction with other state laws to result in coverage by only
6-58 one association.
6-59 SECTION 13. Section 463.202(a), Insurance Code, is amended
6-60 to read as follows:
6-61 (a) Except as limited by this chapter, the coverage provided
6-62 by this chapter to a person specified by Section 463.201, subject to
6-63 Sections 463.201(b) and (c), applies with respect to the following
6-64 policies and contracts issued by a member insurer:
6-65 (1) a direct, nongroup life, health, accident,
6-66 annuity, or supplemental policy or contract, including a health
6-67 maintenance organization contract or certificate;
6-68 (2) a certificate under a direct group policy or
6-69 contract;

7-1 (3) a group hospital service contract; and
7-2 (4) an unallocated annuity contract.
7-3 SECTION 14. Section 463.203, Insurance Code, is amended by
7-4 amending Subsection (b) and adding Subsection (b-1) to read as
7-5 follows:
7-6 (b) This chapter does not provide coverage for:
7-7 (1) any part of a policy or contract not guaranteed by
7-8 the insurer or under which the risk is borne by the policy or
7-9 contract owner;
7-10 (2) a policy or contract of reinsurance, unless an
7-11 assumption certificate has been issued;
7-12 (3) any part of a policy or contract to the extent that
7-13 the rate of interest on which that part is based:
7-14 (A) as averaged over the period of four years
7-15 before the date the member insurer becomes impaired or insolvent
7-16 under this chapter, whichever is earlier, exceeds a rate of
7-17 interest determined by subtracting two percentage points from
7-18 Moody's Corporate Bond Yield Average averaged for the same
7-19 four-year period or for a lesser period if the policy or contract
7-20 was issued less than four years before the date the member insurer
7-21 becomes impaired or insolvent under this chapter, whichever is
7-22 earlier; and
7-23 (B) on and after the date the member insurer
7-24 becomes impaired or insolvent under this chapter, whichever is
7-25 earlier, exceeds the rate of interest determined by subtracting
7-26 three percentage points from Moody's Corporate Bond Yield Average
7-27 as most recently available;
7-28 (4) a portion of a policy or contract issued to a plan
7-29 or program of an employer, association, similar entity, or other
7-30 person to provide life, health, or annuity benefits to the entity's
7-31 employees, members, or others, to the extent that the plan or
7-32 program is self-funded or uninsured, including benefits payable by
7-33 an employer, association, or similar entity under:
7-34 (A) a multiple employer welfare arrangement as
7-35 defined by Section 3, Employee Retirement Income Security Act of
7-36 1974 (29 U.S.C. Section 1002);
7-37 (B) a minimum premium group insurance plan;
7-38 (C) a stop-loss group insurance plan; or
7-39 (D) an administrative services-only contract;
7-40 (5) any part of a policy or contract to the extent that
7-41 the part provides dividends, experience rating credits, or voting
7-42 rights, or provides that fees or allowances be paid to any person,
7-43 including the policy or contract owner, in connection with the
7-44 service to or administration of the policy or contract;
7-45 (6) a policy or contract issued in this state by a
7-46 member insurer at a time the insurer was not authorized to issue the
7-47 policy or contract in this state;
7-48 (7) an unallocated annuity contract issued to or in
7-49 connection with a benefit plan protected under the federal Pension
7-50 Benefit Guaranty Corporation, regardless of whether the Pension
7-51 Benefit Guaranty Corporation has not yet become liable to make any
7-52 payments with respect to the benefit plan;
7-53 (8) any part of an unallocated annuity contract that
7-54 is not issued to or in connection with a specific employee, a
7-55 benefit plan for a union or association of individuals, or a
7-56 governmental lottery;
7-57 (9) any part of a financial guarantee, funding
7-58 agreement, or guaranteed investment contract that:
7-59 (A) does not contain a mortality guarantee; and
7-60 (B) is not issued to or in connection with a
7-61 specific employee, a benefit plan, or a governmental lottery;
7-62 (10) a part of a policy or contract to the extent that
7-63 the assessments required by Subchapter D with respect to the policy
7-64 or contract are preempted by federal or state law;
7-65 (11) a contractual agreement that established the
7-66 member insurer's obligations to provide a book value accounting
7-67 guaranty for defined contribution benefit plan participants by
7-68 reference to a portfolio of assets that is owned by the benefit plan
7-69 or the plan's trustee in a case in which neither the benefit plan

8-1 sponsor nor its trustee is an affiliate of the member insurer;
8-2 (12) a part of a policy or contract to the extent the
8-3 policy or contract provides for interest or other changes in value
8-4 that are to be determined by the use of an index or external
8-5 reference stated in the policy or contract, but that have not been
8-6 credited to the policy or contract, or as to which the policy or
8-7 contract owner's rights are subject to forfeiture, as of the date
8-8 the member insurer becomes an impaired or insolvent insurer under
8-9 this chapter, whichever date is earlier, subject to Subsection (c);
8-10 [~~or~~]
8-11 (13) a policy or contract providing a hospital,
8-12 medical, prescription drug, or other health care benefit under 42
8-13 U.S.C. Sections 1395w-21 et seq. and 1395w-101 et seq. (Medicare
8-14 Parts C and D), 42 U.S.C. Sections 1396-1396w-5 (Medicaid), or 42
8-15 U.S.C. Sections 1397aa-1397mm (State Children's Health Insurance
8-16 Program) or a regulation adopted under those federal statutes; or
8-17 (14) structured settlement annuity benefits to which a
8-18 payee or beneficiary has transferred the payee's or beneficiary's
8-19 rights in a structured settlement factoring transaction as defined
8-20 by Section 5891(c)(3)(A), Internal Revenue Code of 1986 (26 U.S.C.
8-21 Section 5891(c)(3)(A)), regardless of whether the factoring
8-22 transaction occurred before, on, or after the date that section
8-23 became effective.
8-24 (b-1) The exclusion from coverage described by Subsection
8-25 (b)(3) does not apply to any portion of a policy or contract,
8-26 including a rider, that provides long-term care benefits or any
8-27 other health insurance benefit.
8-28 SECTION 15. Section 463.204, Insurance Code, is amended to
8-29 read as follows:
8-30 Sec. 463.204. OBLIGATIONS EXCLUDED. A contractual
8-31 obligation does not include:
8-32 (1) death benefits in an amount in excess of $300,000
8-33 or a net cash surrender or net cash withdrawal value in an amount in
8-34 excess of $100,000 under one or more life insurance policies on a
8-35 single life;
8-36 (2) an amount in excess of:
8-37 (A) $250,000 in the present value under one or
8-38 more annuity contracts issued with respect to a single life under
8-39 individual annuity policies or group annuity policies; or
8-40 (B) $5 million in unallocated annuity contract
8-41 benefits with respect to a single contract owner regardless of the
8-42 number of those contracts;
8-43 (3) an amount in excess of the following amounts,
8-44 including any net cash surrender or cash withdrawal values, under
8-45 one or more accident, health, accident and health, or long-term
8-46 care insurance policies on a single life:
8-47 (A) $500,000 for health benefit plans [~~basic~~
8-48 ~~hospital, medical-surgical, or major medical insurance, as those~~
8-49 ~~terms are defined by this code or rules adopted by the~~
8-50 ~~commissioner~~];
8-51 (B) $300,000 for disability income and long-term
8-52 care insurance, as those terms are defined by this code or rules
8-53 adopted by the commissioner; or
8-54 (C) $200,000 for coverages that are not defined
8-55 as health benefit plans [~~basic hospital, medical-surgical, major~~
8-56 ~~medical~~], disability income, or long-term care insurance;
8-57 (4) an amount in excess of $250,000 in present value
8-58 annuity benefits, in the aggregate, including any net cash
8-59 surrender and net cash withdrawal values, with respect to each
8-60 individual participating in a governmental retirement benefit plan
8-61 established under Section 401, 403(b), or 457, Internal Revenue
8-62 Code of 1986 (26 U.S.C. Sections 401, 403(b), and 457), covered by
8-63 an unallocated annuity contract or the beneficiary or beneficiaries
8-64 of the individual if the individual is deceased;
8-65 (5) an amount in excess of $250,000 in present value
8-66 annuity benefits, in the aggregate, including any net cash
8-67 surrender and net cash withdrawal values, with respect to each
8-68 payee of a structured settlement annuity or the beneficiary or
8-69 beneficiaries of the payee if the payee is deceased;

9-1 (6) aggregate benefits in an amount in excess of
9-2 $300,000 with respect to a single life, except with respect to:
9-3 (A) benefits paid under health benefit plans
9-4 [~~basic hospital, medical-surgical, or major medical insurance~~
9-5 ~~policies~~], described by Subdivision (3)(A), in which case the
9-6 aggregate benefits are $500,000; and
9-7 (B) benefits paid to one owner of multiple
9-8 nongroup policies of life insurance, whether the policy owner is an
9-9 individual, firm, corporation, or other person, and whether the
9-10 persons insured are officers, managers, employees, or other
9-11 persons, in which case the maximum benefits are $5 million
9-12 regardless of the number of policies and contracts held by the
9-13 owner;
9-14 (7) an amount in excess of $5 million in benefits, with
9-15 respect to either one plan sponsor whose plans own directly or in
9-16 trust one or more unallocated annuity contracts not included in
9-17 Subdivision (4) irrespective of the number of contracts with
9-18 respect to the contract owner or plan sponsor or one contract owner
9-19 provided coverage under Section 463.201(a)(3)(B), except that, if
9-20 one or more unallocated annuity contracts are covered contracts
9-21 under this chapter and are owned by a trust or other entity for the
9-22 benefit of two or more plan sponsors, coverage shall be afforded by
9-23 the association if the largest interest in the trust or entity
9-24 owning the contract or contracts is held by a plan sponsor whose
9-25 principal place of business is in this state, and in no event shall
9-26 the association be obligated to cover more than $5 million in
9-27 benefits with respect to all these unallocated contracts;
9-28 (8) any contractual obligations of the insolvent or
9-29 impaired insurer under a covered policy or contract that do not
9-30 materially affect the economic value of economic benefits of the
9-31 covered policy or contract; or
9-32 (9) punitive, exemplary, extracontractual, or bad
9-33 faith damages, regardless of whether the damages are:
9-34 (A) agreed to or assumed by an insurer, [~~or~~]
9-35 insured, or covered person; or
9-36 (B) imposed by a court.
9-37 SECTION 16. Section 463.251(b), Insurance Code, is amended
9-38 to read as follows:
9-39 (b) With the commissioner's approval, the association may:
9-40 (1) guarantee, assume, reissue, or reinsure, or cause
9-41 to be guaranteed, assumed, reissued, or reinsured, one or more of
9-42 the insurer's policies or contracts;
9-43 (2) provide money, pledges, notes, guarantees, or
9-44 other means proper to:
9-45 (A) implement Subdivision (1); and
9-46 (B) ensure payment of the insurer's contractual
9-47 obligations until action is taken under Subdivision (1); or
9-48 (3) loan money to the insurer.
9-49 SECTION 17. Section 463.252(c), Insurance Code, is amended
9-50 to read as follows:
9-51 (c) A policy or contract owner, certificate holder, or
9-52 enrollee who claims emergency or hardship may petition for
9-53 substitute benefits under standards the association proposes and
9-54 the commissioner approves. Substitute benefits are available only
9-55 for a health claim, periodic annuity benefit payment, death
9-56 benefit, supplemental benefit, or cash withdrawal.
9-57 SECTION 18. Section 463.253(b), Insurance Code, is amended
9-58 to read as follows:
9-59 (b) The association shall provide money, pledges,
9-60 guarantees, or other means reasonably necessary to discharge the
9-61 insurer's duties and to:
9-62 (1) guarantee, assume, reissue, or reinsure, or cause
9-63 to be guaranteed, assumed, reissued, or reinsured, the insurer's
9-64 policies or contracts; or
9-65 (2) ensure payment of the insurer's contractual
9-66 obligations.
9-67 SECTION 19. Sections 463.254(b), (e), (f), (g), (h), and
9-68 (i), Insurance Code, are amended to read as follows:
9-69 (b) The association, in accordance with Subsections (c) and

10-1 (d), as applicable, shall ensure payment of benefits identical to
10-2 the benefits that would have been payable under the policy or
10-3 contract of the insurer[~~, at premiums identical to the premiums~~
10-4 ~~that would have been applicable under that policy or contract,~~
10-5 ~~except for terms of conversion and renewability~~].
10-6 (e) The association shall diligently attempt to provide
10-7 each known insured, enrollee, or group policy or contract holder
10-8 [~~policyholder~~] with notice before the 30th day before the date the
10-9 benefits are terminated.
10-10 (f) As provided by Subsections (g)-(i), the association
10-11 shall make substitute coverage available on an individual basis to:
10-12 (1) each known insured or enrollee under an individual
10-13 policy, or the owner if other than the insured or enrollee; and
10-14 (2) each individual who:
10-15 (A) was formerly insured or enrolled under a
10-16 group policy or contract; and
10-17 (B) is not eligible for replacement group
10-18 coverage.
10-19 (g) Substitute coverage is available for an individual
10-20 policy under Subsection (f) only if the insured, enrollee, or owner
10-21 was entitled under law or the terminated policy to continue an
10-22 individual policy in force until a specified age or for a specified
10-23 period during which the insurer:
10-24 (1) was not entitled to unilaterally change a
10-25 provision of the policy; or
10-26 (2) was entitled only to change a premium by class.
10-27 (h) Substitute coverage is available for a group policy or
10-28 contract under Subsection (f) only if the formerly insured or
10-29 enrolled individual was entitled under law or the terminated policy
10-30 or contract to convert group coverage to individual coverage.
10-31 (i) To provide substitute coverage under Subsection (f),
10-32 the association may offer to reissue the terminated coverage or
10-33 issue an alternative policy. The association shall offer the
10-34 reissued or alternative policy without requiring evidence of
10-35 insurability, at actuarially justified rates. The reissued or
10-36 alternative policy may not provide for a waiting period or
10-37 exclusion that would not have applied under the terminated
10-38 policy. The association may reinsure a reissued or alternative
10-39 policy.
10-40 SECTION 20. Section 463.256(b), Insurance Code, is amended
10-41 to read as follows:
10-42 (b) The association shall set the premium according to a
10-43 table of rates the association adopts. The premium:
10-44 (1) must reflect:
10-45 (A) the amount of insurance provided; and
10-46 (B) each insured's or enrollee's age and class of
10-47 risk; and
10-48 (2) may not reflect any change in an insured's or
10-49 enrollee's health occurring after the original policy was most
10-50 recently underwritten.
10-51 SECTION 21. Section 463.258, Insurance Code, is amended to
10-52 read as follows:
10-53 Sec. 463.258. PREMIUM FOR REISSUANCE OF TERMINATED
10-54 COVERAGE. If the association reissues terminated coverage at a
10-55 premium different from the terminated policy's premium, the premium
10-56 must:
10-57 (1) reflect the amount of insurance provided and the
10-58 insured's or enrollee's age and class of risk; and
10-59 (2) be approved by the commissioner or a court.
10-60 SECTION 22. Section 463.260(b), Insurance Code, is amended
10-61 to read as follows:
10-62 (b) The association's obligations with respect to coverage
10-63 under a policy of an impaired or insolvent insurer or under a
10-64 reissued or alternative policy terminate on the date the coverage
10-65 or policy is replaced by another similar policy by the
10-66 policyholder, the contract owner, the insured, the enrollee, or the
10-67 association.
10-68 SECTION 23. Sections 463.261(a) and (c), Insurance Code,
10-69 are amended to read as follows:

11-1 (a) A person receiving a benefit under this chapter,
11-2 including a payment of or on account of a contractual obligation,
11-3 continuation of coverage, or provision of substitute or alternative
11-4 coverage, is considered to have assigned to the association the
11-5 rights under, and any cause of action relating to, the covered
11-6 policy to the extent of the benefit received. The association may
11-7 require a payee, policy or contract owner, beneficiary, insured,
11-8 enrollee, or annuitant to assign the person's rights and cause of
11-9 action to the association as a condition of receiving a right or
11-10 benefit under this chapter.
11-11 (c) The association has all common law rights of subrogation
11-12 and any other equitable or legal remedy that would have been
11-13 available to the impaired or insolvent insurer or holder,
11-14 beneficiary, enrollee, or payee of a policy or contract with
11-15 respect to the policy or contract.
11-16 SECTION 24. Section 463.304, Insurance Code, is amended to
11-17 read as follows:
11-18 Sec. 463.304. DISTRIBUTION OF OWNERSHIP RIGHTS OF IMPAIRED
11-19 OR INSOLVENT INSURER. In making an equitable distribution of the
11-20 ownership rights of an impaired or insolvent insurer before the
11-21 termination of a receivership, the court:
11-22 (1) shall consider the welfare of the policyholders,
11-23 contract owners, certificate holders, and enrollees of the
11-24 continuing or successor insurer; and
11-25 (2) may consider the contributions of the respective
11-26 parties, including the association, the shareholders, [and]
11-27 policyholders, contract owners, certificate holders, and enrollees
11-28 of the impaired or insolvent insurer, and any other party with a
11-29 bona fide interest.
11-30 SECTION 25. Section 463.351(a), Insurance Code, is amended
11-31 to read as follows:
11-32 (a) The commissioner shall:
11-33 (1) notify the insurance officials of all the other
11-34 states, territories of the United States, and the District of
11-35 Columbia by mail not later than the 30th day after the date the
11-36 commissioner:
11-37 (A) revokes or suspends a member insurer's
11-38 certificate of authority; or
11-39 (B) issues a formal order requiring a member
11-40 insurer to:
11-41 (i) restrict the insurer's premium writing;
11-42 (ii) withdraw from this state;
11-43 (iii) reinsure all or part of the insurer's
11-44 business;
11-45 (iv) obtain additional contributions to
11-46 surplus; or
11-47 (v) increase capital, surplus, or another
11-48 account for the security of policyholders, contract owners, or
11-49 creditors;
11-50 (2) report to the board when the commissioner:
11-51 (A) takes an action described by Subdivision (1)
11-52 or receives from another insurance official a report indicating
11-53 that a similar action has been taken in another state; or
11-54 (B) has reasonable cause to believe from a
11-55 completed or continuing examination that a member insurer may be
11-56 impaired or insolvent; and
11-57 (3) provide to the board the National Association of
11-58 Insurance Commissioners Insurance Regulatory Information System
11-59 ratios and listings of insurers not included in those ratios.
11-60 SECTION 26. The changes in law made by this Act apply only
11-61 to an insurer that first becomes impaired or insolvent on or after
11-62 the effective date of this Act.
11-63 SECTION 27. This Act takes effect September 1, 2019.

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