BILL ANALYSIS

Senate Research Center

S.B. 1153
By: Hancock
Business & Commerce
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Enrolled

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Life and health insurers in Texas identified and agreed that changes to the Life and Health Insurance Guaranty Association Act (Act) are needed to reflect the current state of health insurance and health maintenance organizations (HMOs) and to make the assessment methodology for long term care insolvencies more equitable. S.B. 1153 addresses these issues by amending the Act to add: HMOs as member insurers; provisions for coverage of HMO enrollees; allocation of the assessment of long term care insolvencies equally between life and health insurers; and conform, update, and modernize other provisions of the Act. (Original Author's/Sponsor's Statement of Intent)

S.B. 1153 amends current law relating to the Texas Life and Health Insurance Guaranty Association.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 463.002, Insurance Code, as follows:

> Sec. 463.002. PURPOSE. Provides that the purpose of this chapter (Texas Life and Health Insurance Guaranty Association) is to protect, subject to certain limitations, a person specified by Section 463.201 (Insureds Covered) against failure in the performance of a contractual obligation under a life, accident, health, or annuity policy, plan, or contract, rather than under a life, accident, or health insurance policy or annuity contract, with respect to which this chapter provides coverage as determined under Subchapter E (Coverage Provided by Association), because of the impairment or insolvency of the member issuer that issued the policy, plan, or contract, rather than the policy or contract.

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

> (4) Defines "covered policy" or "covered contract" as 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.
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> (4-a) Defines "enrollee."
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> (4-b) Defines "health benefit plan."
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> (5-a) Defines "insurance."
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> (6-a) Defines "insurer."

(7-a) Defines "owner" as the owner of a policy or contract and defines "policyholder," "policy owner," and "contract owner" as the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and is properly recorded as the owner on the books of the member issuer. Provides that the terms "owner," "contract owner," "policyholder," and "policy owner" do not include persons with a mere beneficial interest in a policy or contract.

(9) Defines "premium" and provides that the term does not include:

(A) an amount received for a policy or contract or part of a policy or contract for which coverage is not provided under Section 463.202 (Policies and Contracts Covered), except that assessable premiums are prohibited from being reduced because of:

(i) makes no changes to this subparagraph; or

(ii) a limitation provided by Section 463.204 with respect to a single individual, participant, annuitant, or policy or contract owner;

(B) makes no changes to this paragraph;

(C) premiums received from the state treasury or the United States treasury for insurance for which this state or the United States contracts to:

(i) makes no changes to this paragraph; or

(ii) implement certain laws, including Title 2 (Health), Health and Safety Code; or

(D) makes no changes to this paragraph.

SECTION 3. Amends Subchapter A, Chapter 463, Insurance Code, by adding Sections 463.0032 and 463.007, as follows:

Sec. 463.0032. USE OF TERMS POLICY AND CONTRACT. Defines "policy" and "contract" as having the same meaning for purposes of this chapter.

Sec. 463.007. CONSTRUCTION OF LONG-TERM CARE RIDER. Provides that, for purposes of this chapter, benefits provided by a long-term care rider to a life insurance policy or annuity contract are considered to be the same type of benefits as the base life insurance policy or annuity contract.

SECTION 4. Amends Section 463.052, Insurance Code, as follows:

Sec. 463.052. REQUIRED PARTICIPATION IN ASSOCIATION. (a) Requires, as a condition of engaging in the business of insurance in this state, an insurer, including a mutual assessment company, a local mutual aid association, a statewide mutual assessment company, a stipulated premium company, and a health maintenance organization, rather than a mutual assessment company, a local mutual aid assessment, a statewide mutual aid assessment company, and a stipulated premium company, authorized to engage in business in this state to participate as a member of the association if the insurer holds a certificate of authority to engage in a kind of insurance business in this state with respect to which this chapter provides coverage as determined under Subchapter E.

(b) Provides that the following do not participate as member insurers:

(1) deletes existing text relating to a health maintenance organization and redesignates existing Subdivision (2) as Subdivision (1) and existing Subdivisions (3)–(6) as Subdivisions (2)–(5);

(2)–(4) makes no further changes to these subdivisions; and

(6) an entity similarly to an entity described by Subdivision (1), (2), (3), or (4), rather than Subdivisions (1), (2), (3), (4), or (5).

SECTION 5. Amends Section 463.053, Insurance Code, by adding Subdivision (c-1) to require the commissioner of insurance (commissioner) to consider, among other things, whether the directors appointed under Subsections (b) and (c) (relating to requirements of the composition of the board of directors of the Texas Life and Health Insurance Guaranty Association) fairly represent the member issuers that are health maintenance organizations and life, health, and annuity insurers.

SECTION 6. Amends Sections 463.059(a), (c), and (f), Insurance Code, as follows:

(a) Authorizes the board of directors of the Texas Life and Health Insurance Guaranty Association (board; association) to use telephone conference call, videoconference, or other similar telecommunication method to meet, notwithstanding Chapter 551 (Open Meetings), Government Code, and 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. Deletes existing text authorizing such meeting in certain circumstances.

(c) Requires the notice of a meeting authorized by this section to specify the location of the meeting, rather than 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) Requires the recording of the open portion of the meeting to be posted on the association's Internet website, rather than made available to the public.

SECTION 7. Amends Section 463.101(a), Insurance Code, as follows:

(a) Authorizes the association to:

(1)–(3) makes no changes to these subdivisions;

(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, rather than a domestic life, accident, or health insurance company or a group hospital service corporation, except that the association is prohibited from issuing 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 for an actuarially justified rate or premium increase in accordance with the terms and conditions of a covered policy or contract;

(6) creates Subdivision (6) from existing text and redesignates existing Subdivisions (6)–(7) as Subdivisions (7)–(8); and

(7)–(8) makes no further changes to these subdivisions.

SECTION 8. Amends Section 463.102(b), Insurance Code, as follows:

(b) Provides that an amendment to the association's plan of operation must be approved by the commissioner and takes effect on:

(1) makes no changes to this subdivision; or

(2) the 60th day, rather than the 30th day, after the date the amendment is submitted to the commissioner for approval, if the commissioner does not approve or disapprove the amendment before the 60th day, rather than the 30th day.

SECTION 9. Amends Section 463.109, Insurance Code, as follows:

Sec. 469.109. ASSOCIATION APPEARANCE BEFORE COURT; INTERVENTION. (a) Provides that the association's right to appear applies to:

(1) a proposal for reinsuring, reissuing, modifying, or guaranteeing the insurer's policies or contracts, rather than for reinsuring, modifying, or guaranteeing the insurer's policies or contracts; and

(2)–(3) makes no changes to these subdivisions.

(b) Authorizes the association to appear or intervene before a court in another state with jurisdiction over:

(1) makes no changes to this subdivision; or

(2) a third party against whom the association may have rights through subrogation of the insurer's policyholders or enrollees, rather than the insurer's policyholders.

SECTION 10. Amends Sections 463.114(c), (d), and (e), Insurance Code, as follows:

(c) Prohibits a member insurer, rather than an insurer, at the expiration of the 60th day after approval of the document, from delivering a policy or contract with respect to which this chapter provides coverage as determined under Subchapter E to a policy, contract, or certificate holder or enrollee, rather than to a policy or contract holder, before a copy of the summary document is delivered to the policy, contract, or certificate holder or enrollee, rather than to the policy or contract holder. Requires the document to also be available on request of a policy, contract, or certificate holder or enrollee, rather than request of a policyholder.

(d) Provides that the distribution, delivery, content, or interpretation of a summary document does not guarantee that a policy or contract or a policy, contract, or certificate holder or enrollee, rather than that a policy or contract or a policy or contract holder, is provided coverage by this chapter if a member insurer becomes impaired or insolvent. Provides that failure to receive the document does not give an insured or policy, contract, or certificate holder or enrollee, rather than an insured or policy, contract, or certificate holder, any rights greater than those provided by this chapter.

(e) Prohibits an insurer or agent from delivering a policy or contract described by Section 463.202 that is excluded from the coverage provided by this chapter by Section 463.203 unless the issuer or agent, either before or in conjunction with delivery, gives the policy, contract, or certificate holder or enrollee, rather than the policy or contract holder, a separate written notice clearly and conspicuously disclosing that the policy or contract is not covered by the association.

SECTION 11. Amends Section 463.153, Insurance Code, by amending Subsections (b) and (c) and adding Subsection (b-1), as follows:

(b) Requires Class B assessments on, rather than against, a member insurer for each account under Section 463.105 (Accounts) to be authorized and called in the proportion that the premiums received on business in this state by the member insurer, rather than the insurer, on policies or contracts covered by each account for the three most recent

calendar years for which information is available preceding the year in which the impaired or insolvent member insurer, rather than the insurer, became impaired or insolvent bear to premiums received on business in this state for those calendar years by all assessed member insurers. Requires the amount of a Class B assessment, except for assessments related to long-term care insurance as described by Subsection (b-1), to be allocated among the separate accounts in accordance with an allocation formula that is authorized to be based on certain factors.

(b-1) Requires the amount of a Class B assessment for long-term care insurance written by an impaired or insolvent member insurer to be allocated according to a methodology included in the plan of operation and approved by the commissioner. Requires the methodology to provide for 50 percent of the assessment to be allocated to accident and health members insurers and 50 percent to be allocated to life and annuity member insurers. Provides that this subsection does not apply to a rider to a member insurer's life insurance policy or annuity contract that provides long-term care benefits.

(c) Prohibits the total amount of assessments on a member insurer for each account under Section 463.105 from in one calendar year exceeding two percent of the insurer's average annual premiums on the policies covered by the account during the three calendar years preceding the year in which the impaired or insolvent member insurer, rather than the insurer, became an impaired or insolvent insurer. Requires the average annual premiums for purposes of the aggregate assessment percentage limitation described by this subsection, if two or more assessments are authorized in a calendar year with respect to member insurers, rather than insurers, that become impaired or insolvent in different calendar years, to be equal to the higher of the three-year average annual premiums for the applicable subaccount or account as computed in accordance with this section.

SECTION 12. Amends Sections 463.154 and 463.201, Insurance Code, as follows:

Sec. 463.154. DEFERMENT. Authorizes the association to wholly or partly defer an assessment on a member insurer, rather than an assessment of a member insurer, if the association believes payment of the assessment would endanger the ability of the insurer to fulfill the insurer's contractual obligations.

Sec. 463.201. New heading: PERSONS COVERED. (a) Provides that subject to Subsections (b) and (c), this chapter provides coverage for a policy or contract described by Section 463.202 to a person who is:

(1) a person, other than a certificate holder under a group policy or contract who is not a resident, who is a beneficiary, assignee, or payee, including a health care provider who renders services covered under a health insurance policy or certificate, of a person described by Subdivision (2);

(2) a person who is an owner of or certificate holder or enrollee under, rather than an order of or certificate holder under, a policy or contract specified by Section 463.202, other than an unallocated annuity contract or structured settlement annuity, and who is:

(A) makes no changes to this paragraph; or

(B) not a resident, but only under all of the following conditions:

(i) the member insurers, rather than insurers, that issued the policies or contracts are domiciled in this state;

(ii) makes no changes to this subparagraph; and

(iii) the person is not eligible for coverage by an association in any other state because the insurer or health maintenance

organization, rather than the insurer, was not licensed in the state at the time specified in that state's guaranty association law; or

(3)–(4) makes no changes to these subdivisions.

(b) Provides that this chapter does not provide coverage to:

(1)–(2) makes nonsubstantive changes to these subdivisions; or

(3) a person who acquires rights to receive payments through a structured settlement factoring transaction as defined by Section 5891(c)(3)(A), Internal Revenue Code of 1986 (26 U.S.C. Section 5891(c)(3)(A)), regardless of whether the transaction occurred before, on, or after the date that section became effective.

(c) Requires this chapter, in determining the application of the provisions of this subsection in situations in which a person could be covered by the association of more than one state, whether as an owner, payee, enrollee, beneficiary, or assignee, rather than as an owner, payee, beneficiary, or assignee, to be construed in conjunction with other state laws to result in coverage by only one association.

SECTION 13. Amends Section 463.202(a), Insurance Code, as follows:

(a) Provides that, except as limited by this chapter, the coverage provided by this chapter to a person specified by Section 463.201, subject to Sections 463.201(b) and (c), applies with respect to the following policies and contracts issued by a member insurer:

(1) a direct, nongroup life, health, accident, annuity, or supplemental policy or contract, including a health maintenance organization contract or certificate; and

(2)–(4) makes no changes to these subdivisions.

SECTION 14. Amends Section 463.203, Insurance Code, by amending Subsection (b) and adding Subsection (b-1), as follows:

(b) Provides that this chapter does not provide coverage for:

(1)–(11) makes no changes to these subdivisions;

(12) makes a nonsubstantive change to this subdivision;

(13) a policy or contract providing a hospital, medical, prescription drug, or other health care benefit under 42 U.S.C. Sections 1395w–21 et seq. and 1395w–101 et seq. (Medicare Parts C and D), 42 U.S.C. Sections 1396–1396w–5 (Medicaid), or 42 U.S.C. Sections 1397aa–1397mm (State Children's Health Insurance Program), rather than under 42 U.S.C. Sections 1395w–21 et seq. and 1395w–101 et seq. (Medicare Parts C and D), or a regulation adopted under those federal statutes; or

(14) structured settlement annuity benefits to which a payee or beneficiary has transferred the payee's or beneficiary's rights in a structured settlement factoring transaction as defined by Section 5891(c)(3)(A), Internal Revenue Code of 1986 (26 U.S.C. Section 5891(c)(3)(A)), regardless of whether the factoring transaction occurred before, on, or after the date that section became effective.

(b-1) Provides that the exclusion from coverage described by Subsection (b)(3) does not apply to any portion of a policy or contract, including a rider, that provides long-term care benefits or any other health insurance benefit.

SECTION 15. Amends Section 463.204, Insurance Code, as follows:

Sec. 463.204. OBLIGATIONS EXCLUDED. Provides that a contractual obligation does not include:

(1) death benefits in an amount in excess of $300,000 or a net cash surrender or net cash withdrawal value in an amount in excess of $100,000 under one or more life insurance policies on a single life;

(2) makes no changes to this subdivision;

(3) an amount in excess of the following amounts, including any net cash surrender or cash withdrawal values, under one or more accident, health, accident and health, or long-term care insurance policies on a single life:

(A) $500,000 for health benefit plans, rather than for basic hospital, medical-surgical, or major medical insurance, as those terms are defined by this code or rules adopted by the commissioner;

(B) $300,000 for disability income and long-term care insurance, as those terms are defined by this code or rules adopted by the commissioner; or

(C) $200,000 for coverages that are not defined as health benefit plans, disability income, or long-term care insurance, rather than not defined as basic hospital, medical-surgical, major medical, disability, or long-term care insurance;

(4)–(5) makes no changes to these subdivisions;

(6) aggregate benefits in an amount in excess of $300,000 with respect to a single life, except with respect to:

(A) benefits paid under health benefit plans, rather than under basic hospital, medical-surgical, or major medical insurance policies, described by Subdivision (3)(A), in which case the aggregate benefits are $500,000; and

(B) makes no changes to this paragraph;

(7)–(8) makes no changes to these subdivisions; or

(9) punitive, exemplary, extracontractual, or bad faith damages, regardless of whether the damages are:

(A) agreed to or assumed by an insurer, insured, or covered person, rather than by an insurer or insured; or

(B) makes no changes to this paragraph.

SECTION 16. Amends Section 463.251(b), Insurance Code, as follows:

(b) Requires the association, with the commissioner's approval, to:

(1) guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, one or more of the insurer's policies or contracts; or

(2)–(3) makes no changes to these subdivisions.

SECTION 17. Amends Section 463.252(c), Insurance Code, to authorize a policy or contract owner, certificate holder, or enrollee, rather than a policy or contract owner, who claims

emergency or hardship to petition for substitute benefits under standards the association proposes and the commissioner approves.

SECTION 18. Amends Section 463.253(b), Insurance Code, as follows:

(b) Requires the association to provide money, pledges, guarantees, or other means reasonably necessary to discharge the insurer's duties and to:

(1) guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, the insurer's policies or contracts; or

(2) makes no changes to this subdivision.

SECTION 19. Amends Sections 463.254(b), (e), (f), (g), (h), and (i), Insurance Code, as follows:

(b) Deletes existing text requiring the association to ensure payment of certain benefits at premiums identical to the premiums that would have been applicable under this policy or contract, except for terms of conversion and renewability.

(e) Requires the association to diligently attempt to provide each known insured, enrollee, or group policy or contract holder, rather than each known insured or group policyholder, with notice before the 30th day before the date the benefits are terminated.

(f) Requires the association, as provided by Subsections (g)-(i), to make substitute coverage available on an individual basis to:

(1) each known insured or enrollee under an individual policy, or the owner if other than the insured or enrollee, rather than each insured under an individual policy, or the owner if other than the insured; and

(2) each individual who:

(A) was formerly insured or enrolled, rather than insured, under a group policy or contract; and

(B) makes no changes to this paragraph.

(g) Provides that substitute coverage is available for an individual policy under Subsection (f) only if the insured, enrollee, or owner, rather than the insured or owner, was entitled under law or the terminated policy to continue an individual policy in force until a specified age or for a specified period during which the insurer:

(1)–(2) makes no changes to these subdivisions.

(h) Provides that substitute coverage is available for a group policy or contract under Subsection (f) only if the formerly insured or enrolled, rather than insured, individual was entitled under law or the terminated policy or contract to convert group coverage to individual coverage.

(i) Requires the association to offer the reissued or alternative policy without requiring evidence of insurability, at actuarially justified rates.

SECTION 20. Amends Section 463.256(b), Insurance Code, as follows:

(b) Provides that the premium set by the association:

(1) is required to reflect:

(A) makes no changes to this paragraph; and

(B) each insured's or enrollee's, rather than each enrollee's, age and class of risk; and

(2) is prohibited from reflecting any change in an insured's or enrollee's, rather than an insurer's, health occurring after the original policy was most recently underwritten.

SECTION 21. Amends Section 463.258, Insurance Code, as follows:

Sec. 463.258. PREMIUM FOR REISSUANCE OF TERMINATED COVERAGE. Requires the premium, if the association reissues terminated coverage at a premium different from the terminated policy's premium, to:

(1) reflect the amount of insurance provided and the insured's or enrollee's, rather than the enrollee's, age and class of risk; and

(2) makes no changes to this subdivision.

SECTION 22. Amends Section 463.260(b), Insurance Coverage, to provide that the association's obligations with respect to coverage under a policy of an impaired or insolvent insurer or under a reissued or alternative policy terminate on the date the coverage or policy is replaced by another similar policy by the policyholder, the contract owner, the insured, the enrollee, or the association, rather than the policyholder, the insured, or the association.

SECTION 23. Amends Sections 463.261(a) and (c), Insurance Code, as follows:

(a) Authorizes the association to require a payee, policy or contract owner, beneficiary, insured, enrollee, or annuitant, rather than a payee, policy or contract owner, beneficiary, insured, or annuitant, to assign the person's rights and cause of action to the association as a condition of receiving a right or benefit under this chapter.

(c) Provides that the association has all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or holder, beneficiary, enrollee, or payee of a policy or contract, rather than the impaired of the insolvent insurer or holder of a policy or contract, with respect to the policy or contract.

SECTION 24. Amends Section 463.304, Insurance Code, as follows:

Sec. 463.304. DISTRIBUTION OF OWNERSHIP RIGHTS OF IMPAIRED OR INSOLVENT INSURER. Provides that, in making an equitable distribution of the ownership rights of an impaired or insolvent insurer before the termination of a receivership, the court:

(1) is required to consider the welfare of the policyholders, contract owners, certificate holders, and enrollees of the continuing or successor insurer; and

(2) is authorized to consider the contributions of the respective parties, including the association, the shareholders, policyholders, contract owners, certificate holders, and enrollees of the impaired or insolvent insurer, rather than the association, the shareholders and policyholders of the impaired or insolvent insurer, and any other party with a bona fide interest.

SECTION 25. Amends Section 463.351(a), Insurance Code, as follows:

(a) Requires the commissioner to:

(1) notify the insurance officials of all the other states, territories of the United States, and the District of Columbia by mail not later than the 30th day after the date the commissioner:

(A) makes no changes to this paragraph; or

(B) issues a formal order requiring a member insurer to:

(i)–(iv) makes no changes to these subparagraphs; or

(v) increase capital, surplus, or another account for the security of policyholders, contract owners, or creditors, rather than policyholders or creditors; and

(2)–(3) makes no changes to these subdivisions.

SECTION 26. Makes application of this Act prospective.

SECTION 27. Effective date: September 1, 2019.