State of Tennessee

PUBLIC CHAPTER NO. 5

HOUSE BILL NO. 151

By Representatives Curcio, Gant, Travis

Substituted for: Senate Bill No. 84

By Senators Johnson, Stevens

AN ACT to amend Tennessee Code Annotated, Section 56-12-202; Section 56-12-203; Section 56-12-204; Section 56-12-205; Section 56-12-207; Section 56-12-208 and Section 56-12-218, relative to the Tennessee life and health insurance guaranty association.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 56-12-202, is amended by deleting the current section in its entirety and substituting instead the following:

(a) The purpose of this part is to protect, subject to certain limitations, the persons listed in § 56-12-204(a) against failure in the performance of contractual obligations, under life, health, and annuity policies, plans, or contracts specified in § 56-12-204(b), because of the impairment or insolvency of the member insurer that issued the policies, plans, or contracts.

(b) To provide this protection, an association of member insurers is hereby created to pay benefits and to continue coverages as limited in this part.

(c) Members of the association are subject to assessment to provide funds to carry out the purpose of this part, and shall provide such services as are necessary to implement the protections accorded to policyholders by this part.

SECTION 2. Tennessee Code Annotated, Section 56-12-203, is amended by deleting the current section in its entirety and substituting instead the following:

As used in this part:

(1) "Account" means any of the accounts created under § 56-12-205;

(2) "Association" means the Tennessee life and health insurance guaranty association created under § 56-12-205;

(3) "Commissioner" means the commissioner of commerce and insurance;

(4) "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or a portion thereof, for which coverage is provided under § 56-12-204;

(5) "Covered contract" or "covered policy" means a contract or policy, or a portion of a contract or policy, for which coverage is provided under § 56-12-204;

(6) "Extra-contractual claims" includes, for example, claims relating to bad faith in the payment of claims, punitive or exemplary damages, or attorneys' fees and costs;

(7) "Health benefit plan" means any hospital or medical expense policy or certificate, or health maintenance organization subscriber contract or any other similar health contract. The term does not include accident only insurance, credit insurance, dental only insurance, vision only insurance, Medicare supplement insurance, disability income insurance, coverage for on-site medical clinics,

benefits for long-term care, home health care, community-based care or any combination thereof, specified disease, hospital confinement indemnity, or limited benefit health insurance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates, or other limited benefit or supplemental health insurance excluded from the definition of health insurance in § 56-1-105;

(8) "Impaired insurer" means a member insurer which, after July 1, 1989, is not an insolvent insurer, and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction;

(9) "Insolvent insurer" means a member insurer which, after July 1, 1989, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency;

(10) "Insurance" means life, annuity, and health benefits provided under a contract issued by a member insurer;

(11) "Long-term care insurance" has the same meaning as set forth in § 56-42-103(5);

(12) "Member insurer" means an insurer, health maintenance organization, or nonprofit hospital and medical service organization licensed or that holds a certificate of authority to transact in this state any kind of insurance or health maintenance organization business for which coverage is provided under § 56-12-204, and includes an insurer or health maintenance organization whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn, but does not include:

(A) A fraternal benefit society;

(B) A mandatory state pooling plan;

(C) A mutual assessment company or other person that operates on an assessment basis;

(D) An insurance exchange;

(E) An organization that is authorized under the law of this state to issue charitable gift annuities; or

(F) An entity similar to any of the above;

(13) "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto;

(14) "Owner" of a policy or contract and "policyholder," "policy owner," and "contract owner" mean 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 properly recorded as the owner on the books of the member insurer. "Owner", "policyholder", "policy owner", and "contract owner" does not include persons with a mere beneficial interest in a policy or contract;

(15) "Person" means an individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization;

(16) "Premiums" means amounts or considerations, by whatever name called, received on covered policies or contracts less returned premiums, considerations, and deposits and less dividends and experience credits. "Premiums" does not include amounts or considerations received for policies or contracts, or for the portions of policies or contracts for which coverage is not

provided under § 56-12-204(b), except that assessable premium must not be reduced on account of § 56-12-204(b)(2)(C) relating to interest limitations or § 56-12-204(c)(2) relating to limitations with respect to one (1) individual, one (1) participant, and one (1) policy or contract owner. "Premiums" does not include:

(A) Premiums on an unallocated annuity contract; or

(B) With respect to multiple non-group policies of life insurance owned by one (1) owner, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, premiums in excess of five million dollars ($5,000,000) with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner;

(17) "Principal place of business" of a person, other than a natural person, means the single state in which the natural person who establishes a policy for the direction, control, and coordination of the operations of the entity as a whole, primarily exercises that function as determined by the association in its reasonable judgment by considering the following factors:

(A) The state in which the primary executive and administrative headquarters of the entity is located;

(B) The state in which the principal office of the chief executive officer of the entity is located;

(C) The state in which the board of directors or similar governing person or persons of the entity conducts the majority of its meetings;

(D) The state in which the executive or management committee of the board of directors or similar governing person or persons of the entity conducts the majority of its meetings; and

(E) The state from which the management of the overall operations of the entity is directed;

(18) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the member insurer;

(19) "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer. A person may be a resident of only one (1) state, which, in the case of a person other than a natural person, is its principal place of business. Citizens of the United States who are either residents of foreign countries or residents of United States possessions, territories, or protectorates that do not have an association similar to the association created by this part are deemed residents of the state of domicile of the member insurer that issued the policies or contracts;

(20) "State" means a state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate;

(21) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for, or with respect to, personal injury suffered by the plaintiff or other claimant;

(22) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or contract; and

(23) "Unallocated annuity contract" means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to

the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

SECTION 3. Tennessee Code Annotated, Section 56-12-204, is amended by deleting the current section in its entirety and substituting instead the following:

(a)

(1) This part provides coverage for the policies and contracts specified in subsection (b):

(A) To persons who, regardless of where they reside except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees, or payees, including healthcare providers rendering services covered under health insurance policies or certificates, of persons covered under subdivision (a)(1)(B); and

(B) To persons who are owners of or certificate holders or enrollees under the policies or contracts, other than structured settlement annuities, and who:

(i) Are residents; or

(ii) Are not residents, but only under all of the following conditions:

(a) The member insurer that issued the policies or contracts is domiciled in this state;

(b) The states in which the persons reside have associations similar to the association created by this part; and

(c) The persons are not eligible for coverage by an association in any other state due to the fact that the insurer or the health maintenance organization was not licensed in the state at the time specified in the state's guaranty association law.

(2) For structured settlement annuities specified in subsection (b), subdivisions (a)(1)(A) and (a)(1)(B) do not apply, and this part, except as provided in subdivisions (a)(3) and (a)(4), provides coverage to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

(A) Is a resident, regardless of where the contract owner resides; or

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

(i)

(*a*) The contract owner of the structured settlement annuity is a resident; or

(*b*) The contract owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this state, and the state in which the contract owner resides has an association similar to the association created by this part; and

(ii) Neither the payee, the beneficiary, nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(3) This part does not provide coverage to the following:

(A) A person who is a payee or the beneficiary of a contract owner resident of this state if the payee or beneficiary is afforded any coverage by the association of another state; or

(B) A person who acquires rights to receive payments through a structured settlement factoring transaction as defined in 26 U.S.C. § 5891(c)(3)(A), regardless of whether the transaction occurred before or after that section took effect.

(4) This part provides coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this part is provided coverage under the laws of any other state, the person is not provided coverage under this part. In determining the application of this subdivision (a)(4) in situations where a person could be covered by the association of more than one (1) state, whether as an owner, payee, enrollee, beneficiary, or assignee, this part must be construed in conjunction with other state laws to result in coverage by only one (1) association.

(b)

(1) This part provides coverage to the persons specified in subsection (a) for policies or contracts of direct, non-group life insurance, accident and health insurance, which, for purposes of this part, includes health maintenance organization subscriber contracts and certificates, or annuities, for certificates under direct group policies and contracts, and for supplemental contracts to any of these, in each case issued by member insurers, except as limited by this part. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities, and any immediate or deferred annuity contracts.

(2) Except as otherwise provided in subdivision (b)(3), this part does not provide coverage for:

(A) A portion of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;

(B) A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(C) A portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

(i) Averaged over the period of four (4) years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this part, whichever is earlier, exceeds the rate of interest determined by subtracting two (2) percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four (4) years before the member insurer becomes an impaired or insolvent insurer under this part, whichever is earlier; and

(ii) On and after the date on which the member insurer becomes an impaired or insolvent insurer under this part,

whichever is earlier, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's Corporate Bond Yield Average as most recently available;

(D) A portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others, to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association, or other person under:

(i) A multiple employer welfare arrangement as defined in 29 U.S.C. § 1002(40);

(ii) A minimum premium group insurance plan;

(iii) A stop-loss group insurance plan; or

(iv) An administrative services only contract;

(E) A portion of a policy or contract to the extent that it provides for:

(i) Dividends or experience rating credits;

(ii) Voting rights; or

(iii) Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(F) A policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(G) A portion of a policy or contract to the extent that the assessments required by § 56-12-208 with respect to the policy or contract are preempted by federal or state law;

(H) An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner, or policy owner, including without limitation:

(i) Claims based on marketing materials;

(ii) Claims based on side letters, riders, or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;

(iii) Misrepresentations of or regarding policy or contract benefits;

(iv) Extra-contractual claims; or

(v) A claim for penalties or consequential or incidental damages;

(I) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(J) An unallocated annuity contract;

(K) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this part, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subdivision (b)(2)(K), the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture;

(L) A policy or contract providing any hospital, medical, prescription drug, or other healthcare benefits pursuant to part C or part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code, commonly known as Medicare part C and D, or Subchapter XIX, Chapter 7 of Title 42 of the United States Code, commonly known as Medicaid, or any regulations issued pursuant thereto; or

(M) Structured settlement annuity benefits to which a payee, or beneficiary, has transferred his or her rights in a structured settlement factoring transaction as defined in 26 U.S.C. § 5891(c)(3)(A), regardless of whether the transaction occurred before or after that section became effective.

(3) The exclusion from coverage in subdivision (b)(2)(C) does not apply to any portion of a policy or contract, including a rider, that provides long-term care or any other health insurance benefits.

(c) The benefits that the association may become obligated to cover must in no event exceed the lesser of:

(1) The contractual obligations for which the member insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(2)

(A) With respect to one (1) life, regardless of the number of policies or contracts:

(i) Three hundred thousand dollars ($300,000) in life insurance death benefits, but not more than one hundred thousand dollars ($100,000) in net cash surrender and net cash withdrawal values for life insurance;

(ii) One hundred thousand dollars ($100,000) in health insurance benefits; provided, for policies or contracts issued by a member insurer that becomes insolvent after January 1, 2010, the limits for health insurance benefits are as follows:

(*a*) One hundred thousand dollars ($100,000) for coverages that are not disability income insurance, health benefit plans, or long-term care insurance, including any net cash surrender and net cash withdrawal values;

(*b*) Three hundred thousand dollars ($300,000) for disability income insurance and three hundred thousand dollars ($300,000) for long-term care insurance;

(*c*) Five hundred thousand dollars ($500,000) for health benefit plans; and

(iii) Two hundred fifty thousand dollars ($250,000) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or

(B) With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, two hundred fifty thousand dollars ($250,000) in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(C) The association is not obligated to cover more than:

(i) An aggregate of three hundred thousand dollars ($300,000) in benefits with respect to any one (1) life under subdivisions (c)(2)(A) and (B) except with respect to benefits for health benefit plans under subdivision (c)(2)(A)(ii)(*c*), in which case the aggregate liability of the association must not exceed five hundred thousand dollars ($500,000) with respect to any one (1) individual; or

(ii) With respect to one (1) owner of multiple non-group policies of life insurance, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, more than five million dollars ($5,000,000) in benefits, regardless of the number of policies and contracts held by the owner;

(D) The limitations set forth in this subsection (c) are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this part may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

(E) For purposes of this part, benefits provided by a long-term care rider to a life insurance policy or annuity contract are considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

(d) In performing its obligations to provide coverage under § 56-12-207, the association is not required to guarantee, assume, reinsure, reissue, or perform, or cause to be guaranteed, assumed, reinsured, reissued, or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

SECTION 4. Tennessee Code Annotated, Section 56-12-205, is amended by deleting the current section in its entirety and substituting instead the following:

(a) There is created a nonprofit legal entity to be known as the Tennessee life and health insurance guaranty association. All member insurers are and shall remain members of the association as a condition of their authority to transact insurance or a health maintenance organization business in this state. The association shall perform its function under the plan of operation established and approved pursuant to § 56-12-209, and shall exercise its powers through a board of directors established by § 56-12-206. For purposes of administration and assessment, the association shall maintain two (2) accounts:

(1) The life insurance and annuity account, which includes the following subaccounts:

(A) Life insurance account; and

(B) Annuity account, excluding unallocated annuities; and

(2) The health account.

(b) The association is under the immediate supervision of the commissioner and subject to the applicable provisions of the insurance laws of this state. Meetings or records of the association may be opened upon majority vote of the board of directors of the association.

SECTION 5. Tennessee Code Annotated, Section 56-12-207, is amended by deleting the current section in its entirety and substituting instead the following:

(a) If a member insurer is an impaired insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the commissioner:

(1) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, any or all of the policies or contracts of the impaired insurer; and

(2) Provide monies, pledges, loans, notes, guarantees, or other means as are proper to effectuate subdivision (a)(1) and assure payment of the contractual obligations of the impaired insurer pending action under subdivision (a)(1).

(b) If a member insurer is an insolvent insurer, then the association shall, in its discretion, either:

(1)

(A)

(i) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, the policies or contracts of the insolvent insurer; or

(ii) Assure payment of the contractual obligations of the insolvent insurer; and

(B) Provide monies, pledges, loans, notes, guarantees, or other means reasonably necessary to discharge the association's duties; or

(2) Provide benefits and coverage in accordance with the following provisions:

(A) With respect to policies and contracts, assure payment of benefits that would have been payable under the policies or contracts of the insolvent insurer for claims incurred:

(i) With respect to group policies and contracts, no later than the earlier of the next renewal date under those policies or contracts or forty-five (45) days, but in no event less than thirty (30) days, after the date on which the association becomes obligated with respect to the policies and contracts; and

(ii) With respect to non-group policies, contracts, and annuities no later than the earlier of the next renewal date, if any, under the policies or contracts or one (1) year, but in no event less than thirty (30) days, from the date on which the association becomes obligated with respect to the policies or contracts;

(B) Make diligent efforts to provide all known insureds, enrollees, or annuitants for non-group policies and contracts, or group policy or

contract owners with respect to group policies and contracts, thirty-days' notice of the termination pursuant to subdivision (b)(2)(A), of the benefits provided;

(C) With respect to non-group policies and contracts covered by the association, make available to each known insured, enrollee, or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly an insured, enrollee, or annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with subdivision (b)(2)(D), if the insureds, enrollees, or annuitants had a right under law or the terminated policy, contract, or annuity to convert coverage to individual coverage or to continue an individual policy, contract, or annuity in force until a specified age or for a specified time, during which the insurer or health maintenance organization had no right unilaterally to make changes in any provision of the policy, contract, or annuity or had a right only to make changes in premium by class;

(D)

(i) In providing the substitute coverage required under subdivision (b)(2)(C), the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates subject to the prior approval of the commissioner;

(ii) Alternative or reissued policies or contracts must be offered without requiring evidence of insurability, and must not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract; and

(iii) The association may reinsure any alternative or reissued policy or contract;

(E)

(i) Alternative policies or contracts adopted by the association are subject to the approval of the commissioner. The association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency;

(ii) Alternative policies or contracts must contain at least the minimum statutory provisions required in this state and provide benefits that are not unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates that it shall adopt. The premium must reflect the amount of insurance to be provided and the age and class of risk of each insured, but must not reflect any changes in the health of the insured after the original policy or contract was last underwritten; and

(iii) Any alternative policy or contract issued by the association must provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the association;

(F) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium must be actuarially justified and set by the association in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to prior approval of the commissioner;

(G) The association's obligations with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy or contract ceases on the date the coverage or policy or contract is replaced by another similar policy or contract by the policy or contract owner, the insured, the enrollee, or the association; and

(H) When proceeding under this subdivision (b)(2), with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with § 56-12-204(b)(2)(C).

(c) Nonpayment of premiums within thirty-one (31) days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage terminates the association's obligations under the policy, contract, or coverage under this part with respect to the policy, contract, or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with this part.

(d) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer belong to and are payable at the direction of the association. If the liquidator of an insolvent insurer requests, the association shall provide a report to the liquidator regarding such premium collected by the association. The association is liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(e) The protection provided by this part does not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(f) In carrying out its duties under subsection (b), the association may:

(1) Subject to approval by a court in this state, impose permanent policy or contract liens in connection with a guarantee, assumption, or reinsurance agreement if the association finds that the amounts that can be assessed under this part are less than the amounts needed to assure full and prompt performance of the association's duties under this part, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of permanent policy or contract liens, to be in the public interest; or

(2) Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans, or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(g) The commissioner shall promptly pay to the association a deposit in this state, held pursuant to law or required by the commissioner for the benefit of creditors, including policy or contract owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of a member insurer domiciled in this state or in a reciprocal state, pursuant to § 56-9-409. The association is entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy or contract owners' claims related to that insolvency for which the association has provided statutory

benefits by the aggregate amount of all policy or contract owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association less the amount retained pursuant to this subsection (g). Any amount so paid to the association and retained by it is treated as a distribution of estate assets pursuant to applicable state receivership law dealing with early access disbursements.

(h) If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subsection (b), then the commissioner has the powers and duties of the association under this part with respect to the insolvent insurer.

(i) The association may render assistance and advice to the commissioner, upon the commissioner's request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of an impaired or insolvent insurer.

(j) The association has standing to appear or intervene before a court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this part, or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Standing extends to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, reissuing, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association also has the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(k)

(1) A person receiving benefits under this part is deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from, or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of this part, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative policies, contracts, or coverages. The association may require an assignment to it of the rights and cause of action by any enrollee, payee, policy, or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this part upon the person.

(2) The subrogation rights of the association under this subsection (k) have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this part.

(3) In addition to subdivisions (k)(1) and (2), 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 owner, beneficiary, enrollee, or payee of a policy or contract with respect to the policy or contracts.

(4) If the preceding provisions of this subsection (k) are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations must be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or contracts or portion thereof covered by the association.

(5) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in this subsection (k), the person shall pay to the association the portion of the recovery attributable to the policies or contracts or portion thereof covered by the association.

(l) In addition to the rights and powers elsewhere in this part, the association may:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this part;

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under § 56-12-208 and to settle claims or potential claims against it;

(3) Borrow money to effect the purposes of this part. Any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic member insurers and may be carried as admitted assets;

(4) Employ or retain persons as are necessary or appropriate to handle the financial transactions of the association, and to perform other functions as become necessary or proper under this part;

(5) Take legal action as may be necessary or appropriate to avoid or recover payment of improper claims;

(6) Exercise, for the purposes of this part and to the extent approved by the commissioner, the powers of a domestic life insurer, health insurer, or health maintenance organization, but in no case may the association issue policies or contracts other than those issued to perform its obligations under this part;

(7) Organize itself as a corporation or in other legal form permitted by the laws of the state;

(8) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this part with respect to the person, and the person shall promptly comply with the request;

(9) Unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under this part; and

(10) Take other necessary or appropriate action to discharge its duties and obligations under this part or to exercise its powers under this part.

(m) The association may join an organization of one (1) or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

(n)

(1)

(A) At any time within one hundred eighty (180) days of the date of the order of liquidation, the association may elect to succeed to the rights and obligations of the ceding member insurer that relate to policies, contracts, or annuities covered, in whole or in part, by the association, in each case under any one (1) or more reinsurance contracts entered into by the insolvent insurer and its reinsurers and selected by the association. Any assumption is effective as of the date of the order of liquidation. The election is effected by the association or the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) on its behalf sending written notice, return receipt requested, to the affected reinsurers.

(B) To facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance, and in order to protect the

financial position of the estate, the receiver and each reinsurer of the ceding member insurer shall make the following available upon request to the association or to NOLHGA on its behalf as soon as possible after commencement of formal delinquency proceedings:

(i) Copies of in-force contracts of reinsurance and all related files and records relevant to the determination of whether the contracts should be assumed; and

(ii) Notices of any defaults under the reinsurance contracts or any known event or condition that with the passage of time could become a default under the reinsurance contracts.

(C) The following apply to reinsurance contracts assumed by the association:

(i) The association is responsible for all unpaid premiums due under the reinsurance contracts for periods both before and after the date of the order of liquidation, and is responsible for the performance of all other obligations to be performed after the date of the order of liquidation, in each case that relates to policies, contracts, or annuities covered, in whole or in part, by the association. The association may charge policies, contracts, or annuities covered in part by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association and shall provide notice and an accounting of these charges to the liquidator;

(ii) The association is entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods after the date of the order of liquidation and that relate to policies, contracts, or annuities covered, in whole or in part, by the association. Upon receipt of any such amounts, the association is obliged to pay to the beneficiary under the policy, contracts, or annuity on account of which the amounts were paid a portion of the amount equal to the lesser of:

(*a*) The amount received by the association; or

(*b*) The excess of the amount received by the association over the amount equal to the benefits paid by the association on account of the policy, contracts, or annuity less the retention of the insurer applicable to the loss or event;

(iii) Within thirty (30) days following the association's election, the association and each reinsurer under contracts assumed by the association shall calculate the net balance due to or from the association under each reinsurance contract as of the election date with respect to policies, contracts, or annuities covered, in whole or in part, by the association, which calculation must give full credit to all items paid by either the member insurer or its receiver or the reinsurer prior to the election date. The reinsurer shall pay the receiver any amounts due for losses or events prior to the date of the order of liquidation, subject to any set-off for premiums unpaid for periods prior to the date, and the association or reinsurer shall pay any remaining balance due the other, in each case within five (5) days of the completion of the calculation. Any disputes over the amounts due to either the association or the reinsurer must be resolved by arbitration pursuant to the terms of the affected reinsurance contracts or, if the contract contains no arbitration clause, as otherwise provided by law. If the receiver has received any amounts due the

association pursuant to subdivision (n)(1)(C)(ii), the receiver shall remit the same to the association as promptly as practicable; and

(iv) If the association or receiver, on the association's behalf, within sixty (60) days of the election date, pays the unpaid premiums due for periods both before and after the election date that relate to policies, contracts, or annuities covered, in whole or in part, by the association, the reinsurer is not entitled to terminate the reinsurance contracts for failure to pay premium insofar as the reinsurance contracts relate to policies, contracts, or annuities covered, in whole or in part, by the association, and is not entitled to set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the association, against amounts due the association.

(2) During the period from the date of the order of liquidation until the election date, or, if the election date does not occur, until one hundred eighty (180) days after the date of the order of liquidation:

(A)

(i) Neither the association nor the reinsurer has any rights or obligations under reinsurance contracts that the association has the right to assume under subdivision (n)(1), whether for periods prior to or after the date of the order of liquidation; and

(ii) The reinsurer, the receiver, and the association shall, to the extent practicable, provide each other data and records reasonably requested; and

(B) Provided that once the association has elected to assume a reinsurance contract, the parties' rights and obligations are governed by subdivision (n)(1).

(3) If the association does not elect to assume a reinsurance contract by the election date pursuant to subdivision (n)(1), the association has no rights or obligations for periods both before and after the date of the order of liquidation, with respect to the reinsurance contract.

(4) When policies, contracts, or annuities, or covered obligations with respect thereto, are transferred to an assuming insurer, then the association may also transfer the reinsurance on the policies, contracts, or annuities in the case of contracts assumed under subdivision (n)(1), subject to the following:

(A) Unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred does not cover any new policies of insurance, contracts, or annuities in addition to those transferred;

(B) The obligations described in subdivision (n)(1) no longer apply with respect to matters arising after the effective date of the transfer; and

(C) The transferring party shall give notice in writing, return receipt requested, to the affected reinsurer not less than thirty (30) days prior to the effective date of the transfer.

(5) This subsection (n) supersedes the provisions of any state law or of any affected reinsurance contract that provides for or requires any payment of reinsurance proceeds on account of losses or events that occur in periods after the date of the order of liquidation to the receiver of the insolvent insurer or any other person. The receiver remains entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods prior to the date of the order of liquidation, subject to applicable set-off provisions.

(6) Except as otherwise provided in this section, nothing in this subsection (n) alters or modifies the terms and conditions of any reinsurance contract. Nothing in this section abrogates or limits any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract. Nothing in this section gives a policyholder, contract owner, enrollee, certificate holder, or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract. Nothing in this section limits or affects the association's rights as a creditor of the estate against the assets of the estate. Nothing in this section applies to reinsurance agreements covering property or casualty risks.

(o) The board of directors of the association has discretion and shall exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this part in an economical and efficient manner.

(p) Where the association has arranged or offered to provide the benefits of this part to a covered person under a plan or arrangement that fulfills the association's obligations under this part, the person is not entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(q) Venue in a suit against the association arising under this part is in chancery court of Davidson County. The association is not required to give an appeal bond in an appeal that relates to a cause of action arising under this part.

(r) In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under this section, the association may issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following:

(1) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for:

(A) A fixed interest rate;

(B) Payment of dividends with minimum guarantees; and

(C) A different method for calculating interest or changes in value;

(2) There is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract; and

(3) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

SECTION 6. Tennessee Code Annotated, Section 56-12-208, is amended by deleting the current section in its entirety and substituting instead the following:

(a) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments are due not less than thirty (30) days after prior written notice to the member insurers and accrue interest at ten percent (10%) per annum on and after the due date.

(b) There are two (2) classes of assessments, as follows:

(1) Class A assessments are made for the purpose of meeting administrative and legal costs and other expenses and examinations conducted under the authority of § 56-12-211(e). Class A assessments may be made whether or not related to a particular impaired or insolvent insurer; and

(2) Class B assessments are made to the extent necessary to carry out the powers and duties of the association pursuant to § 56-12-207 with regard to an impaired or an insolvent insurer.

(c)

(1) The amount of any Class A assessment is determined by the board and may be made on a pro rata or non-pro rata basis. If pro rata, the board may provide that it be credited against future Class B assessments.

(2) The amount of any Class B assessment, except for assessments related to long-term care insurance, must be allocated for assessment purposes between the accounts and subaccounts of the life insurance and annuity account pursuant to an allocation formula that may be based on the premiums or reserves of the impaired or insolvent insurer, or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

(3) The amount of the Class B assessment for long-term care insurance written by the impaired or insolvent member insurer must be allocated according to a methodology included in the plan of operation and approved by the commissioner. The methodology must provide for fifty percent (50%) of the assessment to be allocated to accident and health member insurers and fifty percent (50%) allocated to life and annuity member insurers.

(4) Class B assessments against member insurers for each account and subaccount must be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three (3) most recent calendar years for which information is available preceding the year in which the member insurer became impaired or insolvent, as the case may be, bears to the premiums received on business in this state for those calendar years by all assessed member insurers.

(5) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer must not be made until necessary to implement the purposes of this part. Classification of assessments by subsection (b) and computation of assessments by this subsection (c) must be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(d) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

(e)

(1)

(A) Subject to subdivision (e)(1)(B), the total of all assessments authorized by the association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the health account must not in one (1) calendar year exceed two percent (2%) of that member insurer's average annual premiums received in this state on the policies and contracts covered by the subaccount or account during the three (3) calendar years preceding the year in which the member insurer became an impaired or insolvent insurer.

(B) If two (2) or more assessments are authorized in one (1) calendar year with respect to member insurers that become impaired or insolvent in different calendar years, the average annual premiums for

purposes of the aggregate assessment percentage limitation referenced in subdivision (e)(1)(A) must be equal and limited to the higher of the three-year average annual premiums for the applicable subaccount or account as calculated pursuant to this section.

(C) If the maximum assessment, together with the other assets of the association in an account, does not provide in one (1) year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds must be assessed as soon thereafter as permitted by this part.

(2) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one (1) or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(3) If the maximum assessment for a subaccount of the life and annuity account in one (1) year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to subdivision (c)(2), the board has the authority to assess the other subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in subdivision (e)(1).

(f) The board may, by an equitable method established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains, and income from investment. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future claims.

(g) It is proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance or health maintenance organization business within the scope of this part, to consider the amount reasonably necessary to meet its assessment obligations under this part.

(h) The association shall issue to each member insurer paying an assessment under this part, other than Class A assessments, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment paid. All outstanding certificates must be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in the form and for the amount, if any, and period of time as the commissioner may approve.

(i)

(1) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment set forth in the notice provided by the association so that the payment is available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment must be accompanied by a written statement that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

(2) Except as provided in subdivision (i)(4), within sixty (60) days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(3) Within thirty (30) days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty (60) days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the commissioner.

(4) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the commissioner for a final decision, with or without a recommendation from the association.

(5) If the protest or appeal on the assessment is upheld, then the association shall return the amount paid in error or excess plus applicable interest to the member insurer. Interest on a refund due a protesting member insurer must be paid at the rate actually earned by the association.

(j) The association may request information of member insurers in order to aid in the exercise of its power under this section, and member insurers shall promptly comply with a request.

SECTION 7. Tennessee Code Annotated, Section 56-12-218, is amended by deleting the current section in its entirety and substituting instead the following:

(a) No person, including a member insurer or agent or affiliate of a member insurer shall make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly to be made, published, disseminated, circulated, or placed before the public in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television broadcast, or in any other way, any advertisement, announcement, or statement, written or oral, that uses the existence of the Tennessee life and health insurance guaranty association for the purpose of sales, solicitation, or inducement to purchase any form of insurance or other coverage covered by this part. However, this section does not apply to the Tennessee life and health insurance guaranty association or any other entity that does not sell or solicit insurance or coverage by a health maintenance organization.

(b) The association shall prepare a summary document that describes the general purposes and current limitations of this part and that complies with subsection (c). This document must be submitted to the commissioner for approval. At the expiration of the sixtieth day after the date on which the commissioner approves the document, a member insurer shall not deliver a policy or contract to a policy owner, contract owner, certificate holder, or enrollee unless the summary document is delivered to the policy owner, contract owner, certificate holder, or enrollee at the time of delivery of the policy or contract. The document must also be available upon request by a policy owner, contract owner, certificate holder, or enrollee. The distribution, delivery, or contents or interpretation of this document does not guarantee that either the policy or the contract, or the policy owner, contract owner, certificate holder, or enrollee is covered in the event of the impairment or insolvency of a member insurer. The association shall revise the document as amendments to this part require. Failure to receive the summary document does not give the policy owner, contract owner, certificate holder, enrollee, or insured any greater rights than those stated in this part.

(c) The document prepared under subsection (b) must contain a clear and conspicuous disclaimer on its face. The commissioner shall establish the form and content of the disclaimer. The disclaimer must:

(1) State the name and address of the Tennessee life and health insurance guaranty association and department of commerce and insurance;

(2) Prominently warn the policy owner, contract owner, certificate holder, or enrollee that the Tennessee life and health insurance guaranty association may not cover the policy or contract or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in this state;

(3) State the types of policies or contracts for which guaranty funds will provide coverage;

(4) State that the member insurer and its agents are prohibited by law from using the existence of the Tennessee life and health insurance guaranty

association for the purpose of sales, solicitation, or inducement to purchase any form of insurance or health maintenance organization coverage;

(5) State that the policy owner, contract owner, certificate holder, or enrollee should not rely on coverage under the Tennessee life and health insurance guaranty association when selecting an insurer or health maintenance organization;

(6) Explain the rights available and procedures provided for filing a complaint to allege a violation of this part; and

(7) Provide other information as directed by the commissioner, including, but not limited to, sources for information about the financial condition of insurers; provided, that the information is not proprietary or is not protected from disclosure under Tennessee's public records law.

(d) A member insurer shall retain evidence of compliance with subsection (b) for so long as the policy or contract for which the notice is given remains in effect.

SECTION 8. The provisions of sections 2-6 of this act shall not apply to any member insurer that is impaired or insolvent on the effective date of this act.

SECTION 9. This act shall take effect July 1, 2019, the public welfare requiring it.

HOUSE BILL NO. 151

PASSED: March 4, 2019

GLEN CASADA, SPEAKER
HOUSE OF REPRESENTATIVES

RANDY MCNALLY
SPEAKER OF THE SENATE

APPROVED this 20th day of March 2019

BILL LEE, GOVERNOR