SENATE BILL 2863
By Stewart

HOUSE BILL 3002

By McDaniel

AN ACT to amend Tennessee Code Annotated, Title 56, Chapter 12, 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 56-12-203, is amended by deleting the section in its entirety and by 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 policy" means a policy or contract, or a portion of a policy or contract, for which coverage is provided under § 56-12-204;

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

(7) "Health insurance benefits" means benefits payable under any form of accident and health insurance policy;

(8) “Impaired insurer” means a member insurer which, after the effective date of this part, 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 the effective date of this part, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency;

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whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include: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

(B) A fraternal benefit society;

(C) A mandatory state pooling plan;

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

(E) An insurance exchange;

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

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

(11) “Moody’s Corporate Bond Yield Average” means the Monthly Average Corporates as published by Moody’s Investors Service, Inc., or any successor thereto;

(12) “Owner” of a policy or contract and “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 insurer. The terms owner, contract owner and policy owner do not include persons with a mere beneficial interest in a policy or contract;

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

(14) "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 shall 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 individual, one participant and one contract owner. "Premiums" shall not include:

(A) Premiums on an unallocated annuity contract; or

(B) With respect to multiple non-group policies of life insurance owned by one owner, whether the policy 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;

(15) "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;

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

(17) "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 state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States that are either (i) residents of foreign countries; or (ii) residents of United States possessions, territories or protectorates that do not have an association similar to the association created by this part, shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts;

(18) "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;

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

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

(21) "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 2. Tennessee Code Annotated, Section 56-12-204, is amended by deleting the section in its entirety and by substituting instead the following:

(a) This part shall provide coverage for the policies and contracts specified in subsection (b):

(1) To persons who, regardless of where they reside except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees or payees of persons covered under subdivision (a)(2);

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

(A) Are residents; or

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

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

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

(iii) The persons are not eligible for coverage by an association in any other state due to the fact that the insurer was not licensed in the state at the time specified in the state's guaranty association law;

(3) For structured settlement annuities specified in subsection (b), subdivisions (a)(1) and (a)(2) shall not apply, and this part shall, except as provided in subdivisions (a)(4) and (a)(5), provide 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, or the beneficiary nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides;

(4) This part shall not provide coverage to 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

(5) This part is intended to provide 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, such person shall not be provided coverage under this part. In determining the application of the provisions of this subdivision in situations where a person could be covered by the association of more than one (1) state, whether as an owner, payee, beneficiary or assignee, this part shall be construed in conjunction with other state laws to result in coverage by only one (1) association.

(b)

(1) This part shall provide coverage to the persons specified in subsection (a) for direct, non-group life, accident and health, or annuity policies or contracts and supplemental contracts to any of these and for certificates under direct group policies and contracts, 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) This part shall not provide coverage for:

(A) A portion of a policy or contract not guaranteed by the 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. § 1144;

(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 insurer to the 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 insurer without meeting applicable policy form filing or approval requirements;

(iii) Misrepresentations of or regarding policy 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, 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; or

(L) A policy or contract providing any hospital, medical, prescription drug or other health care 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& D, or any regulations issued pursuant thereto.

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

(1) The contractual obligations for which the 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, 2011, the limits established by this subdivision (c)(2)(A)(ii) shall be increased to three hundred thousand dollars ($300,000);

(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) However, in no event shall the association be obligated to cover more than:

(i) an aggregate of three hundred thousand dollars $300,000 in benefits with respect to any (1) one life under subdivision (c)(2)(B); or

(ii) with respect to one (1) owner of multiple non-group policies of life insurance, whether the policy 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.

(d) In performing its obligations to provide coverage under § 56-12-207, the association shall not be required to guarantee, assume, reinsure or perform, or cause to be guaranteed, assumed, reinsured 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 3. Tennessee Code Annotated, Section 56-12-205, is amended by adding a new, appropriately designated subsection as follows:

(__) Effective January 1, 2011, the association shall maintain the following three (3) accounts:

(1) A life insurance account;

(2) An annuity account; and

(3) A health insurance account.

SECTION 4. Tennessee Code Annotated, Section 56-12-207, is amended by deleting the section in its entirety and by 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 or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer; or

(2) Provide such 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, the association shall, in its discretion, either:

(1)

(A)

(i) Guarantee, assume or reinsure, or cause to be guaranteed, assumed 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 life and health insurance policies and annuities, assure payment of benefits for premiums identical to the premiums and benefits except for terms of conversion and renewability 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;

(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 or annuitants for non-group policies and contracts, or group policy owners with respect to group policies and contracts, thirty (30) days notice of the termination pursuant to subdivision (b)(2)(A), of the benefits provided;

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

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

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

(E)

(i) Alternative policies adopted by the association shall be subject to the approval of the domiciliary insurance commissioner and the receivership court. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

(ii) Alternative policies shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be 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 shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten.

(iii) Any alternative policy issued by the association shall provide coverage of a type similar to that of the policy 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, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the domiciliary insurance commissioner and the receivership court.

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

(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 shall terminate the association's obligations under the policy or coverage under this part with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this part.

(d) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be 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 shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(e) The protection provided by this part shall 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 which 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 such 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) A deposit in this state, held pursuant to law or required by the commissioner for the benefit of creditors, including policy owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state, pursuant to § 56-9-409 shall be promptly paid to the association. The association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy owners claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy 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. Any amount so paid to the association and retained by it shall be 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) of this section, the commissioner shall have 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 shall have 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 shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, 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 shall also have 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 shall be 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 coverages. The association may require an assignment to it of such rights and cause of action by any 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) shall 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 (k)(2) above, the association shall have 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 or payee of a policy or contract with respect to the policy or contracts including without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary or payee of the annuity, to the extent of benefits received pursuant to this part, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under 26 U.S.C. § 130, et seq.

(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 shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies 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 the preceding subdivisions of this subsection (k), the person shall pay to the association the portion of the recovery attributable to the policies 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 such 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 insurers and may be carried as admitted assets;

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

(5) Take such 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 or health insurer, but in no case may the association issue insurance policies or annuity 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; and

(9) 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 or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

(n) With respect to covered policies for which the association becomes obligated after an entry of an order of liquidation, the association may elect to succeed to the rights of the insolvent insurer arising after the order of liquidation under any contract of reinsurance to which the insolvent insurer was a party, to the extent that such contract provides coverage for losses occurring after the date of the order of liquidation or rehabilitation. As a condition to making this election, the association must pay all unpaid premiums due under the contract for coverage relating to periods before and after the date of the order of liquidation or rehabilitation.

(o) The board of directors of the association shall have discretion and may 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 shall not be 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 shall be in Chancery Court of Davidson County. The association shall not be 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 or reinsuring policies or contracts under this section, the association may, subject to

approval of the receivership court, 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 provisions:

(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 5. This act shall take effect upon becoming a law, the public welfare requiring it.