

A NONSUBSTANTIVE REVISION
OF STATUTES RELATING TO
INSURANCE FEES AND TAXES, CONSUMER INTERESTS,
HEALTH INSURANCE AND RELATED PRODUCTS, TITLE INSURANCE,
AND INSURANCE INDUSTRY PROFESSIONALS

Submitted to the 78th Legislature
as part of the
Texas Legislative Council's
Statutory Revision Program

Austin, Texas

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FOREWORD

The Texas Legislative Council is required by law (Section 323.007, Government Code) to carry out a complete nonsubstantive revision of the Texas statutes. The process involves reclassifying and rearranging the statutes in a more logical order, employing a numbering system and format that will accommodate future expansion of the law, eliminating repealed, invalid, duplicative, and other ineffective provisions, and improving the draftsmanship of the law if practicable--all toward promoting the stated purpose of making the statutes "more accessible, understandable, and usable" without altering the sense, meaning, or effect of the law.

Under the new classification scheme adopted by the council, the statutes will eventually consist of 27 codes. To date, the council has produced and the legislature has enacted the Agriculture Code, Alcoholic Beverage Code, Business & Commerce Code, Civil Practice and Remedies Code, Education Code, Election Code (which was a substantive revision), Finance Code, Government Code, Health and Safety Code, Human Resources Code, Labor Code, Local Government Code, Natural Resources Code, Occupations Code, Parks and Wildlife Code, Property Code, Special District Local Laws Code, Tax Code (Title 1 of which was a substantive revision), Transportation Code, Utilities Code, and Water Code. The council staff also assisted the state bar in the Business Organizations Code, Penal Code, and Family Code projects, which were substantive revisions, and revised miscellaneous criminal procedure provisions as Title 2 of the Code of Criminal Procedure.

Titles 3, 5, 9, 11, and 13 and Subtitles A-G and I, Title 8, Insurance Code, are a nonsubstantive revision of the Texas statutes relating to insurance fees and taxes, consumer interests, health insurance and related products, title insurance, and insurance industry professionals. These titles are derived from provisions of the Insurance Code of 1951 previously designated as part of Title 1, Insurance Code.

When the revision of the Insurance Code is complete, the code will be divided into titles, subtitles, chapters, subchapters, and sections. Sections will be numbered decimally, and the number to the left of the decimal point is the same as the chapter number. Note that gaps in chapter and section numbering are for future expansion. The material that has been incorporated in this nonsubstantive revision by the 78th Legislature is added to the Insurance Code of 1951 as Titles 3, 5, 9, 11, and 13 and Subtitles A-G and I, Title 8. Material incorporated into the revision of the Insurance Code by the 77th Legislature is designated as Titles 6 and 7 and Subtitle H, Title 8. Material incorporated into the revision of the Insurance Code by the 76th Legislature is designated as Title 2. Existing material in the Insurance Code that is not affected by any revision is contained in Title 1.

The revisor's report reflects Titles 3, 5, 9, 11, and 13 and Subtitles A-G and I, Title 8, Insurance Code, as enacted by the passage of H.B. No. 2922, Acts of the 78th Legislature, Regular Session, 2003. The revisor's report states the Revised Law, which is the text of the new law, and then provides the Source Law, which

is the text of the former law from which the revised law is derived. If further explanation of either the revised law or the source law is required, a Revisor's Note is included after the source law. All substance in the source law is revised in the revised law or the reason for its omission is explained in a revisor's note.

Note that, to provide all affected parties a complete legislative cycle to more closely review the revision, Titles 3, 5, 9, 11, and 13 and Subtitles A-G and I, Title 8, Insurance Code, will not take effect until April 1, 2005.

Because of the extensive reorganization of many statutes, and even sentences within a statute, it may be helpful to refer to the source law as printed in the Insurance Code as it existed before the revision (so that the quoted source law may be seen in its former context) and to the disposition table (showing where the former statutes appear, as revised, in the code). The disposition table is printed as Appendix C to the revisor's report.

The revision required conforming amendments to several statutes. These conforming amendments, which were also enacted into law by the passage of H.B. No. 2922, are printed in Appendix A to the revisor's report. Appendix A also includes a section listing the laws repealed effective April 1, 2005, and a section stating the legislature's intent that the code be a nonsubstantive revision.

In reviewing the revisor's report to Titles 3, 5, 9, 11, and 13 and Subtitles A-G and I, Title 8, Insurance Code, the reader should keep in mind the following:

(1) Except as provided by Section 30.003, Insurance Code, as amended by H.B. No. 2922, the Code Construction Act (Chapter 311, Government Code) applies to the code. That act sets out certain principles of statutory construction applicable to new codes and also provides some definitions. The act is printed as Appendix B to the revisor's report.

(2) The proposed code is written in modern American English. Where possible, the present tense is used; the active rather than the passive voice is preferred; and the singular is used in preference to the plural.

(3) This is a nonsubstantive revision. The staff's authority does not include improving the substance of law. The sole purpose of this project was to compile all the relevant law, arrange it in a logical fashion, and rewrite it without altering its meaning or legal effect. If a particular source statute is ambiguous and the ambiguity cannot be resolved without a potential substantive effect, the ambiguity was preserved.

This project was under the direction of Kelley Atkinson, Legislative Counsel, of the council staff. Questions may be directed to her at P.O. Box 12128, Capitol Station, Austin, Texas 78711, or at telephone number (512) 463-1155.

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3 CHAPTER 201. COLLECTION OF REVENUE AND ADMINISTRATION OF FUNDS

4 SUBCHAPTER A. GENERAL PROVISIONS

5 Revised Law

6 Sec. 201.001. TEXAS DEPARTMENT OF INSURANCE OPERATING
7 ACCOUNT. (a) The Texas Department of Insurance operating account
8 is an account in the general revenue fund. The account includes the
9 following:

10 (1) taxes and fees received by the commissioner or
11 comptroller that are required by this code to be deposited to the
12 credit of the account; and

13 (2) money or credits received by the department or
14 commissioner from sales, reimbursements, and fees authorized by law
15 other than this code, including money or credits received from:

16 (A) charges for providing copies of public
17 information under Chapter 552, Government Code;

18 (B) the disposition of surplus or salvage
19 property under Subchapters C and D, Chapter 2175, Government Code;

20 (C) the sale of publications and other printed
21 material under Section 2052.301, Government Code;

22 (D) miscellaneous transactions and sources under
23 Section 403.011 or 403.012, Government Code;

24 (E) charges for postage spent to serve legal
25 process under Section 17.025, Civil Practice and Remedies Code;

26 (F) the comptroller involving warrants for which
27 payment is barred under Chapter 404, Government Code;

28 (G) sales or reimbursements authorized by the
29 General Appropriations Act; and

30 (H) the sale of property purchased with money
31 from the account or a predecessor fund or account.

32 (b) The commissioner shall administer money in the account
33 and may spend money from the account in accordance with state law,
34 rules adopted by the commissioner, and the General Appropriations

1 Act.

2 (c) Money deposited to the credit of the account may be used
3 for any purpose for which money in the account is authorized to be
4 used by law. (V.T.I.C. Art. 1.31A, Secs. 2, 3, 4, 5, 6(a).)

5 Source Law

6 Sec. 2. The Texas Department of Insurance
7 operating fund is a fund in the State Treasury.

8 Sec. 3. Money received by the commissioner or
9 comptroller from taxes and fees that are required by
10 this code to be credited to the fund and money received
11 by the commissioner from sales, reimbursements, and
12 fees authorized by law other than this code shall be
13 deposited in the fund.

14 Sec. 4. The money received from sales,
15 reimbursements, and other fees authorized by law other
16 than this code includes money received from the
17 following:

18 (1) fees received by the department for
19 providing copies of public records under Chapter 552,
20 Government Code;

21 (2) money or credits received by the
22 department for surplus or salvage property under
23 Subchapters C and D, Chapter 2175, Government Code;

24 (3) money received by the department from
25 the sale of publications and other printed material
26 under Sections 2052.301 and 2052.302, Government Code;

27 (4) receipts to the department from
28 miscellaneous transactions and sources under Section
29 403.011 or 403.012, Government Code, as amended;

30 (5) money received by the department from
31 charges for postage spent to serve legal process under
32 Section 17.025, Civil Practice and Remedies Code;

33 (6) receipts to the department from the
34 comptroller involving warrants for which payment is
35 barred under Chapter 404, Government Code, as amended;

36 (7) money received by the department from
37 sales or reimbursements authorized by the General
38 Appropriations Act; and

39 (8) money received by the department from
40 the sale of any property purchased with money from the
41 fund or a predecessor fund.

42 Sec. 5. The money in the fund may be used for the
43 purposes for which any of the money deposited in the
44 fund is authorized to be used by law.

45 Sec. 6. (a) The commissioner shall administer
46 and may spend money from the fund pursuant to laws of
47 the state, rules adopted by the commissioner, and the
48 General Appropriations Act.

49 Revisor's Note

50 (1) Section 2, V.T.I.C. Article 1.31A, creates
51 an operating fund in the state treasury for the Texas
52 Department of Insurance. Under the authority of
53 Chapter 4, Acts of the 72nd Legislature, 1st Called
54 Session, 1991, the Texas Department of Insurance
55 operating fund was converted to an account in the

1 general revenue fund. Throughout this chapter,
2 references to the fund have been changed as
3 appropriate. In addition, Section 1, V.T.I.C. Article
4 1.31A, defines "fund" as the Texas Department of
5 Insurance operating fund. The revised law omits this
6 definition as unnecessary and because the fund is now
7 an account. The omitted law reads:

8 Art. 1.31A

9 Sec. 1. In this article, "fund" means
10 the Texas Department of Insurance operating
11 fund.

12 (2) Section 4(1), V.T.I.C. Article 1.31A,
13 refers to fees received for providing copies of
14 "public records" under Chapter 552, Government Code.
15 Chapter 1035, Acts of the 74th Legislature, Regular
16 Session, 1995, changed the heading of Chapter 552,
17 Government Code, from "Open Records" to "Public
18 Information" and in addition deleted references to
19 "public records" and instead referred to "information"
20 or "public information" throughout Chapter 552. For
21 consistency with those changes, the revised law
22 substitutes "public information" for "public
23 records."

24 (3) Section 4(3), V.T.I.C. Article 1.31A,
25 requires that money received by the department from
26 the sale of publications and other printed material
27 under "Sections 2052.301 and 2052.302, Government
28 Code," be deposited to the credit of the Texas
29 Department of Insurance operating fund. Section
30 2052.302, Government Code, prohibits an officer or
31 employee of the state from receiving an economic
32 benefit from an activity related to an agency
33 publication or other printed material and does not
34 relate to the authority of the Texas Department of
35 Insurance to receive money for such a publication or

1 other printed material. Therefore, the revised law
2 omits the reference to Section 2052.302, Government
3 Code.

4 (4) Sections 4(4) and (6), V.T.I.C. Article
5 1.31A, refer to Section 403.011 or 403.012, Government
6 Code, "as amended," and Chapter 404, Government Code,
7 "as amended." The revised law omits the references to
8 "as amended" because under Section 311.027, Government
9 Code (Code Construction Act), unless expressly
10 provided otherwise, a reference to a statute applies
11 to all reenactments, revisions, or amendments of the
12 statute.

13 Revised Law

14 Sec. 201.002. ACCOUNTING PROCEDURE. The commissioner
15 shall maintain a procedure to account for the receipt,
16 disbursement, and allocation of money deposited in the Texas
17 Department of Insurance operating account, including recordkeeping
18 procedures adequate for:

19 (1) the commissioner or comptroller, as applicable, to
20 adjust the tax assessments and fee schedules as authorized by this
21 code; and

22 (2) the state auditor to determine the source of all
23 receipts and expenditures. (V.T.I.C. Art. 1.31A, Sec. 6(b).)

24 Source Law

25 (b) The commissioner is responsible for the
26 development and maintenance of an accounting procedure
27 for the receipt, allocation, and disbursement of money
28 deposited in the fund. The procedure shall require
29 adequate records for the commissioner or comptroller,
30 if applicable, to adjust the tax assessments and fee
31 schedules as authorized by this code and for the State
32 Auditor to determine the source of all receipts and
33 expenditures.

34 Revisor's Note

35 Section 6(b), V.T.I.C. Article 1.31A, provides
36 for the "development and maintenance of an accounting
37 procedure." The revised law omits the reference to
38 "development" of the procedure as executed.

1 Revised Law

2 Sec. 201.003. REFUNDS. If the department determines that a
3 person, firm, or corporation through mistake of law or fact
4 erroneously paid or overpaid a fee or other amount of money,
5 including any interest or penalty, administered or collected by the
6 department, the department may refund the erroneous payment or
7 overpayment by warrant on the state treasury from any funds
8 appropriated for that purpose. (V.T.I.C. Art. 1.31.)

9 Source Law

10 Art. 1.31. This article applies to any tax, fee,
11 or other sum of money, including any interest or
12 penalty, collected or administered by the State Board
13 of Insurance. When the State Board of Insurance
14 determines that any person, firm, or corporation has
15 through mistake of law or fact overpaid or paid
16 erroneously any amount to the state on any tax, fee, or
17 other sum of money, including any interest or penalty,
18 collected or administered by the State Board of
19 Insurance, the State Board of Insurance may refund
20 such payment by warrant on the state treasury from any
21 funds appropriated for such purpose.

22 Revisor's Note

23 (1) V.T.I.C. Article 1.31 refers to the "State
24 Board of Insurance." Chapter 685, Acts of the 73rd
25 Legislature, Regular Session, 1993, abolished the
26 board and transferred its functions to the
27 commissioner of insurance and the Texas Department of
28 Insurance. Throughout this chapter, references to the
29 board have been changed appropriately.

30 (2) V.T.I.C. Article 1.31 provides that the
31 department may refund any tax "collected or
32 administered by the State Board of Insurance" that is
33 overpaid or paid erroneously. Chapter 685, Acts of the
34 73rd Legislature, Regular Session, 1993, transferred
35 to the comptroller responsibility for the
36 administration, collection, enforcement, and
37 reporting of insurance taxes, "[e]xcept as otherwise
38 expressly provided for in this code or another
39 insurance law of this state." There is no other law

1 that provides for an entity other than the comptroller
2 to administer, collect, enforce, and report insurance
3 taxes. In addition, the comptroller's office has
4 confirmed that the comptroller administers, collects,
5 enforces, and reports all insurance taxes. Therefore,
6 the revised law omits the reference to taxes because
7 the department and commissioner no longer administer
8 insurance taxes.

9 Revised Law

10 Sec. 201.004. ELECTRONIC TRANSFERS. (a) The commissioner
11 shall adopt rules for the electronic transfer of any fee, guarantee
12 fund, or other money owed to or held for the benefit of this state
13 that the department has the responsibility to administer under this
14 code or another insurance law of this state.

15 (b) The commissioner shall require the electronic transfer
16 of any amount held or owed that exceeds \$500,000. (V.T.I.C.
17 Art. 1.10, Sec. 20.)

18 Source Law

19 Sec. 20. The Commissioner shall adopt rules for
20 the electronic transfer of any taxes, fees, guarantee
21 funds, or other money owed to or held for the benefit
22 of the state and for which the Department has the
23 responsibility to administer under this code or
24 another insurance law of this state. The Commissioner
25 shall require the electronic transfer of any amounts
26 held or owed in an amount exceeding \$500,000.

27 Revisor's Note

28 Section 20, V.T.I.C. Article 1.10, requires the
29 commissioner to adopt rules for the electronic
30 transfer of "taxes . . . for which the Department has
31 the responsibility to administer" The revised
32 law omits the references to taxes for the reason stated
33 in Revisor's Note (2) to Section 201.003.

34 Revised Law

35 Sec. 201.005. TRANSFER OF SECURITIES. (a) A transfer by
36 the department of any security that is held in any way by the
37 department is not valid unless the transfer is countersigned by the

1 comptroller.

2 (b) The comptroller shall:

3 (1) countersign any security transfer presented by the
4 department;

5 (2) keep a record of all transfers that includes:

6 (A) the name of the transferee, unless the
7 security is transferred in blank; and

8 (B) a description of the security;

9 (3) when countersigning a security transfer, advise
10 the company concerned by mail of the details of the transaction; and

11 (4) state, in the comptroller's annual report to the
12 legislature, the countersigned transfers and the amount of the
13 transfers.

14 (c) To verify the correctness of records:

15 (1) the department is entitled to free access to the
16 comptroller's records kept under Subsection (b); and

17 (2) the comptroller is entitled to free access to the
18 books and other department documents relating to securities held by
19 the department. (V.T.I.C. Arts. 1.20, 1.21, 1.22.)

20 Source Law

21 Art. 1.20. No transfer by the Board of
22 securities of any kind, in any way held by it, shall be
23 valid unless countersigned by the comptroller.

24 Art. 1.21. It is the duty of the comptroller:

25 1. To countersign any such transfer
26 presented to him by the Board.

27 2. To keep a record of all transfers,
28 stating the name of the transferee, unless transferred
29 in blank, and a description of the security.

30 3. Upon countersigning, to advise by mail
31 the company concerned, the particulars of the
32 transaction.

33 4. In his annual report to the Legislature
34 to state the transfers and the amount thereof,
35 countersigned by him.

36 Art. 1.22. To verify the correctness of
37 records, the Board shall be entitled to free access to
38 the comptroller's records, required by the preceding
39 article, and the comptroller shall be entitled to free
40 access to the books and other documents of the
41 Insurance Department relating to securities held by
42 the Board.

43 Revisor's Note
44 (End of Subchapter)

45 V.T.I.C. Article 1.31B provides that the board's

1 financial transactions are subject to audit by the
2 state auditor. The revised law omits the article as
3 unnecessary because Section 321.013, Government Code,
4 requires the state auditor to conduct audits of all
5 departments as specified in the audit plan. It is
6 unnecessary to repeat that provision in this chapter.
7 The omitted law reads:

8 Art. 1.31B. The financial
9 transactions of the State Board of
10 Insurance are subject to audit by the state
11 auditor in accordance with Chapter 321,
12 Government Code.

13 [Sections 201.006-201.050 reserved for expansion]

14 SUBCHAPTER B. ADMINISTRATION

15 Revised Law

16 Sec. 201.051. POWERS AND DUTIES OF COMPTROLLER. (a)
17 Except as otherwise provided by this code or another insurance law
18 of this state, the comptroller shall administer and enforce the
19 provisions of this code and other insurance laws of this state that
20 relate to the administration, collection, and reporting of taxes
21 and certain fees and assessments imposed under this code or another
22 insurance law of this state, as specifically provided by this code.

23 (b) The comptroller may:

24 (1) adopt rules to implement the administration,
25 collection, reporting, and enforcement responsibilities assigned
26 to the comptroller under this code or another insurance law of this
27 state; and

28 (2) prescribe appropriate report forms, establish or
29 alter tax report due dates not otherwise specifically prescribed by
30 this code or another insurance law of this state, and otherwise
31 adapt the functions transferred to the comptroller under Chapter
32 685, Acts of the 73rd Legislature, Regular Session, 1993, to
33 increase efficiency and cost-effectiveness.

34 (c) A rule adopted by the comptroller that relates to the
35 administration, collection, reporting, or enforcement of taxes
36 imposed under this code prevails over a conflicting rule, policy,

1 or procedure established by the department, the commissioner, or
2 otherwise.

3 (d) Subtitles A and B, Title 2, Tax Code, apply to the
4 administration, collection, and enforcement by the comptroller of
5 taxes and certain fees and assessments under this code or another
6 insurance law of this state. Except as otherwise provided by this
7 code, the powers granted to the comptroller under those provisions
8 of the Tax Code do not limit and are exclusive of the powers granted
9 to the department or the commissioner in relation to other fees and
10 assessments under this code. (V.T.I.C. Art. 1.04D, Secs. (a), (c),
11 (d).)

12 Source Law

13 Art. 1.04D. (a) Except as otherwise expressly
14 provided for in this code or another insurance law of
15 this state, the comptroller shall administer, enforce,
16 and carry out the provisions of this code and other
17 insurance laws of this state that relate to the
18 collection, reporting, and administration of taxes and
19 certain fees and assessments imposed under this code
20 or another insurance law of this state, as
21 specifically provided in this code.

22 (c) The comptroller may adopt rules to carry out
23 the collection, reporting, enforcement, and
24 administration responsibilities assigned to the
25 comptroller under this code or another insurance law
26 of this state. The comptroller may also prescribe
27 appropriate report forms, establish or alter tax
28 return due dates not otherwise specifically set forth
29 in this code or another insurance law of this state,
30 and otherwise adapt the functions transferred to the
31 comptroller to increase efficiency and
32 cost-effectiveness. With respect to rules related to
33 the collection, reporting, enforcement, or otherwise
34 to the administration of taxes imposed under this
35 code, rules adopted by the comptroller shall prevail
36 in the event of conflict with rules, policies, or
37 procedures established by the department, the
38 commissioner, or otherwise.

39 (d) With respect to the comptroller's
40 performance of the duties relative to the taxes, fees,
41 and assessments imposed under this code or another
42 insurance law of this state, the comptroller has the
43 administrative, enforcement, and collection powers
44 provided by Subtitles A and B, Title 2, Tax Code, and
45 their subsequent amendments. Except as otherwise
46 expressly provided by this code, those powers are
47 granted to the comptroller without limiting and
48 exclusive of powers granted to the department or the
49 commissioner with respect to other fees and
50 assessments under this code.

51 Revisor's Note

52 (1) Section (a), V.T.I.C. Article 1.04D,

1 requires the comptroller to administer, enforce, and
2 "carry out" the law relating to the collection,
3 reporting, and administration of insurance taxes and
4 certain fees and assessments. The revised law omits
5 the reference to "carry out" as unnecessary because,
6 in context, it is included within the meaning of
7 "administer" and "enforce."

8 (2) Section (c), V.T.I.C. Article 1.04D, refers
9 to a "tax return." Throughout this chapter, the
10 revised law substitutes "tax report" for "tax return"
11 because, in the context of tax law, a "tax return" is
12 synonymous with a "tax report" and the latter is more
13 commonly used.

14 (3) Section (c), V.T.I.C. Article 1.04D, refers
15 to "functions transferred to the comptroller," meaning
16 functions transferred by Chapter 685, Acts of the 73rd
17 Legislature, Regular Session, 1993, which transferred
18 to the comptroller the duties relating to the
19 administration, collection, enforcement, and
20 reporting of insurance taxes and certain fees and
21 assessments. The revised law adds a reference to this
22 law for clarity and for the convenience of the reader.

23 (4) Section (d), V.T.I.C. Article 1.04D, refers
24 to Subtitles A and B, Title 2, Tax Code, "and their
25 subsequent amendments." The revised law omits the
26 reference to "and their subsequent amendments" for the
27 reason stated in Revisor's Note (4) to Section 201.001.

28 Revised Law

29 Sec. 201.052. REIMBURSEMENT. (a) The department shall
30 reimburse the appropriate portion of the general revenue fund for
31 the amount of expenses incurred by the comptroller in administering
32 taxes imposed under this code or another insurance law of this
33 state.

34 (b) The comptroller shall certify to the commissioner the

1 total amount of expenses estimated to be required to perform the
2 comptroller's duties under this code or another insurance law of
3 this state for each fiscal biennium. The comptroller shall provide
4 copies of the certification to the budget division of the
5 governor's office and to the Legislative Budget Board.

6 (c) The amount certified by the comptroller shall be
7 transferred from the Texas Department of Insurance operating
8 account to the appropriate portion of the general revenue fund. It
9 is the legislature's intent that money in the Texas Department of
10 Insurance operating account to be transferred under this subsection
11 should reflect the revenues from maintenance taxes paid by insurers
12 under this code or another insurance law of this state.

13 (d) In setting maintenance taxes for each fiscal year, the
14 commissioner shall ensure that the amount of taxes imposed is
15 sufficient to fully reimburse the appropriate portion of the
16 general revenue fund for the amount of expenses incurred by the
17 comptroller in administering taxes imposed under this code or
18 another insurance law of this state.

19 (e) If the amount of maintenance taxes collected is not
20 sufficient to reimburse the appropriate portion of the general
21 revenue fund for the amount of expenses incurred by the
22 comptroller, other money in the Texas Department of Insurance
23 operating account shall be used to reimburse the appropriate
24 portion of the general revenue fund. (V.T.I.C. Art. 4.19.)

25 Source Law

26 Art. 4.19. (a) The department shall reimburse
27 the general revenue fund for the amount of expenses
28 incurred by the comptroller in administering the taxes
29 imposed under this code or another insurance law of
30 this state in accordance with this article.

31 (b) The comptroller shall certify to the
32 commissioner the total amount of expenses estimated to
33 be required to perform the comptroller's duties under
34 this code or another insurance law of this state for
35 each fiscal biennium. The comptroller shall provide
36 copies of the certification to the budget division of
37 the governor's office and to the Legislative Budget
38 Board.

39 (c) The amount certified by the comptroller
40 under Subsection (b) of this article shall be
41 transferred from the Texas Department of Insurance
42 operating fund to the general revenue fund. It is the

1 intent of the legislature that the money in the
2 department's operating fund that is to be transferred
3 into the general revenue fund under this subsection
4 should reflect the revenues from the various
5 maintenance taxes paid by insurers under this code or
6 other insurance laws of this state.

7 (d) In setting the maintenance taxes for each
8 fiscal year, the commissioner shall ensure that the
9 amount of the taxes imposed is sufficient to fully
10 reimburse the general revenue fund for the expenses
11 incurred by the comptroller in administering the taxes
12 imposed under this code and other insurance laws of
13 this state. If the amount of maintenance taxes
14 collected is insufficient to reimburse the general
15 revenue fund for the expenses incurred by the
16 comptroller in administering the taxes imposed under
17 this code and other insurance laws of this state, other
18 money in the department's operating fund shall be used
19 to reimburse the general revenue fund in accordance
20 with Subsection (b) of this article.

21 Revisor's Note

22 V.T.I.C. Article 4.19 requires that the Texas
23 Department of Insurance "reimburse the general revenue
24 fund" for the amount of the comptroller's expenses in
25 administering the collection of insurance taxes, with
26 the amount of the reimbursement transferred from "the
27 Texas Department of Insurance operating fund to the
28 general revenue fund." Because the Texas Department
29 of Insurance operating fund has been converted to an
30 account in the general revenue fund, the revised law
31 substitutes a requirement that "the appropriate
32 portion of the general revenue fund" be reimbursed.
33 This substitution reflects the clear intent of the
34 legislature that money be transferred from the Texas
35 Department of Insurance operating account to a portion
36 of the general revenue fund from which the money may be
37 appropriated to pay for the comptroller's expenses
38 incurred in performing duties under the Insurance
39 Code.

40 Revised Law

41 Sec. 201.053. COOPERATION BETWEEN DEPARTMENT AND
42 COMPTROLLER. The commissioner and the comptroller shall cooperate
43 fully in performing their respective duties under this code or
44 another insurance law of this state. (V.T.I.C. Art. 4.18, Sec.

1 (a.)

2 Source Law

3 Art. 4.18. (a) The commissioner and the
4 comptroller shall cooperate fully in performing their
5 respective duties under this code and other insurance
6 laws of this state.

7 Revised Law

8 Sec. 201.054. INFORMATION SHARING; FEDERAL IDENTIFICATION
9 NUMBERS. (a) The department shall comply with each reasonable
10 request from the comptroller relating to the sharing of information
11 gathered or compiled in connection with functions the comptroller
12 performs under this code or another insurance law of this state.

13 (b) The department shall maintain a record of the federal
14 identification number of each entity subject to regulation under
15 this code or another insurance law of this state and shall include
16 the appropriate number in any communication to or information
17 shared with the comptroller relating to that entity. (V.T.I.C.
18 Art. 4.18, Secs. (b), (c).)

19 Source Law

20 (b) The department shall comply with all
21 reasonable requests of the comptroller relating to the
22 sharing of information gathered or compiled in
23 connection with functions carried out under this code
24 or other insurance laws of this state.

25 (c) The department shall maintain the federal
26 identification number of all entities subject to
27 regulation under this code or another insurance law of
28 this state and shall include the appropriate number in
29 any communication to or information shared with the
30 comptroller.

31 Revised Law

32 Sec. 201.055. FILING DATE OF REPORT OR PAYMENT DELIVERED BY
33 POSTAL SERVICE. Except as otherwise specifically provided, for a
34 report, including a tax report, or payment that is required to be
35 filed or made in the offices of the comptroller and that is
36 delivered by the United States Postal Service to the offices of the
37 comptroller after the date on which the report or payment is
38 required to be filed or made, the date of filing or payment is the
39 date of:

40 (1) the postal service postmark stamped on the cover

1 in which the report or payment is mailed; or
2 (2) any other evidence of mailing authorized by the
3 postal service reflected on the cover in which the report or payment
4 is mailed. (V.T.I.C. Art. 1.11 (part), as amended Acts 77th Leg.,
5 R.S., Ch. 1419.)

6 Source Law

7 Art. 1.11. If . . . any report, tax return, or
8 payment required to be filed or deposited in the
9 offices of the comptroller, is delivered by the United
10 States Postal Service to the offices of the
11 . . . comptroller, as required, after the prescribed
12 date on which the report, . . . tax return, or payment
13 is to be filed, the date of the United States Postal
14 Service postmark stamped on the cover in which the
15 document is mailed, or any other evidence of mailing
16 authorized by the United States Postal Service
17 reflected on the cover in which the document is mailed,
18 shall be deemed to be the date of filing, unless
19 otherwise specifically made an exception to this
20 general statute.

21 CHAPTER 202. FEES

22 SUBCHAPTER A. GENERAL PROVISIONS

23 Sec. 202.001. APPLICABILITY OF CHAPTER. 23
24 Sec. 202.002. DETERMINATION OF FEES 24
25 Sec. 202.003. FEES FOR COPIES 24
26 Sec. 202.004. REDUCED FEES FOR CERTAIN INSURERS. 25

27 [Sections 202.005-202.050 reserved for expansion]

28 SUBCHAPTER B. SPECIFIC MAXIMUM FEES

29 Sec. 202.051. GENERAL FEES IMPOSED ON INSURERS 25
30 Sec. 202.052. FEES IMPOSED ON CERTAIN INSURERS 28

31 [Sections 202.053-202.100 reserved for expansion]

32 SUBCHAPTER C. DEPOSIT AND USE OF FEES

33 Sec. 202.101. DEPOSIT AND USE OF FEES GENERALLY 30
34 Sec. 202.102. DEPOSIT AND USE OF CERTAIN OTHER FEES. 31

35 CHAPTER 202. FEES

36 SUBCHAPTER A. GENERAL PROVISIONS

37 Revised Law

38 Sec. 202.001. APPLICABILITY OF CHAPTER. Except as provided
39 by Section 202.052, the insurers that are subject to a fee imposed
40 under this chapter include:

- 1 (1) stock insurance companies;
- 2 (2) mutual insurance companies;
- 3 (3) local mutual aid associations;
- 4 (4) statewide mutual assessment companies;
- 5 (5) group hospital service corporations; and
- 6 (6) stipulated premium companies. (V.T.I.C.
- 7 Art. 4.07, Sec. D.)

8 Source Law

9 D. Except as provided by Section B of this
10 Article, the insurers subject to the fees imposed by
11 this Article shall include any and all stock and mutual
12 insurance companies, local mutual aid associations,
13 statewide mutual assessment companies, group hospital
14 service plan corporations, and stipulated premium
15 insurance companies.

16 Revisor's Note

17 Section D, V.T.I.C. Article 4.07, refers to
18 "group hospital service plan corporations." The term
19 most frequently used to refer to such corporations is
20 "group hospital service corporations." Consequently,
21 the revised law substitutes for the quoted language
22 "group hospital service corporations" to provide for
23 consistent use of terminology throughout this code.

24 Revised Law

25 Sec. 202.002. DETERMINATION OF FEES. The department shall,
26 subject to the limits established by this chapter, set the amount of
27 the fees imposed under this chapter. (V.T.I.C. Art. 4.07, Secs. A
28 (part), C.)

29 Source Law

30 A. . . . [the Texas Department of Insurance
31 shall charge . . . fees in an amount] to be determined
32 by the department

33 C. The department shall, within the limits fixed
34 by this Article, prescribe the fees to be charged under
35 this Article.

36 Revised Law

37 Sec. 202.003. FEES FOR COPIES. (a) The department shall
38 set and collect a fee for copying any paper of record with the
39 department. The fee shall be set in an amount sufficient to

1 reimburse the state for the actual expense.

2 (b) The department may make and distribute copies of a paper
3 containing rating information without charge or for a fee that the
4 commissioner considers appropriate for administering the premium
5 rating laws by properly distributing rating information.

6 (c) This section does not affect Article 5.29. (V.T.I.C.
7 Art. 4.07, Sec. E.)

8 Source Law

9 E. The Texas Department of Insurance shall set
10 and collect a sales charge for making copies of any
11 paper of record in the Texas Department of Insurance,
12 such charge to be in an amount deemed sufficient to
13 reimburse the State for the actual expense; provided,
14 however, that the department may make and distribute
15 copies of papers containing rating information without
16 charge or for such charge as the commissioner shall
17 deem appropriate to administer the premium rating laws
18 by properly disseminating such rating information; and
19 provided further that Article 5.29, Texas Insurance
20 Code, shall remain in full force and effect without
21 amendment.

22 Revised Law

23 Sec. 202.004. REDUCED FEES FOR CERTAIN INSURERS. An
24 insurer to which this chapter applies that had gross premium
25 receipts of less than \$450,000, according to the insurer's annual
26 statement for the preceding year ending December 31, is required to
27 pay only one-half the amount of a fee otherwise required to be paid
28 under this chapter. (V.T.I.C. Art. 4.07, Sec. H.)

29 Source Law

30 H. Notwithstanding any other provision of this
31 article, any insurer to which this article applies and
32 whose gross premium receipts are less than
33 \$450,000.00, according to its annual statement for the
34 preceding year ending December 31, shall be required
35 to pay only one-half the amount of the fees required to
36 be paid under this article and as set by the
37 commissioner.

38 [Sections 202.005-202.050 reserved for expansion]

39 SUBCHAPTER B. SPECIFIC MAXIMUM FEES

40 Revised Law

41 Sec. 202.051. GENERAL FEES IMPOSED ON INSURERS. The
42 department shall impose and receive fees for the use of the state
43 from each authorized insurer writing insurance in this state. The

1 amount of the fees may not exceed:

2 (1) for filing an amendment to a certificate of
3 authority if the charter is not amended \$100;

4 (2) for affixing the official seal and certifying to
5 the seal \$20;

6 (3) for reservation of name \$200;

7 (4) for renewal of reservation of name \$50;

8 (5) for filing an application for admission of a
9 foreign or alien insurer \$4,000;

10 (6) for filing an original charter of an insurer,
11 including issuance of a certificate of authority \$3,000;

12 (7) for filing an amendment to a charter if a hearing
13 is held \$500;

14 (8) for filing an amendment to a charter if a hearing
15 is not held \$250;

16 (9) for filing a designation of an attorney for
17 service of process or an amendment of a designation \$50;

18 (10) for filing a copy of a total reinsurance
19 agreement \$1,500;

20 (11) for filing a copy of a partial reinsurance
21 agreement \$300;

22 (12) for accepting a security deposit \$200;

23 (13) for substitution or amendment of a security
24 deposit \$100;

25 (14) for certification of a statutory deposit . . \$20;

26 (15) for filing a notice of intent to locate books and
27 records outside this state under Chapter 803 \$300;

28 (16) for filing a statement under Subchapters D
29 and E, Chapter 823, for the first \$9.9 million of the
30 consideration \$1,000;

31 (17) for filing a statement under Subchapters D and E,
32 Chapter 823, if the amount of the consideration exceeds \$9.9
33 million an additional \$500 for each additional
34 \$10 million of the consideration that exceeds \$9.9 million, but not

1 more than a total amount of \$10,000 under this subdivision and
2 Subdivision (16);

3 (18) for filing a registration statement under
4 Subchapter B, Chapter 823 \$300;

5 (19) for filing for review under Subchapter C, Chapter
6 823, or Subchapter L, Chapter 884 \$500;

7 (20) for filing a direct reinsurance agreement under
8 Subchapter K, Chapter 884 \$300;

9 (21) for filing for approval of a merger under Chapter
10 824 \$1,500;

11 (22) for filing for approval of reinsurance under
12 Chapter 828 \$1,500;

13 (23) for filing restated articles of incorporation for
14 a domestic, foreign, or alien insurer \$500;

15 (24) for filing a joint control agreement . . . \$100;

16 (25) for filing a substitution or amendment to a joint
17 control agreement \$40; and

18 (26) for filing a change of attorney in fact . . \$500.

19 (V.T.I.C. Art. 4.07, Sec. A (part).)

20 Source Law

21 Art. 4.07. A. With respect to all authorized
22 insurers writing classes of insurance in this State,
23 the Texas Department of Insurance shall charge and
24 receive for the use of the State fees in an amount
25 . . . not to exceed the following:

26 (1) For filing an amendment to a
27 certificate of authority if the charter is not
28 amended, \$100.00.

29 (2) For affixing the official seal and
30 certifying to the seal, \$20.00.

31 (3) For reservation of name, \$200.00.

32 (4) For renewal of reservation of name,
33 \$50.00.

34 (5) For filing an application for
35 admission of a foreign or alien company, \$4,000.00.

36 (6) For filing an original charter of a
37 company including issuance of a certificate of
38 authority, \$3,000.00.

39 (7) For filing an amendment to a charter if
40 a hearing is held, \$500.00.

41 (8) For filing an amendment to a charter if
42 a hearing is not held, \$250.00.

43 (9) For filing a designation of an
44 attorney for service of process or amendment of the
45 designation, \$50.00.

46 (10) For filing a copy of a total
47 reinsurance agreement, \$1,500.00.

1 (11) For filing a copy of a partial
2 reinsurance agreement, \$300.00.

3 (12) For accepting a security deposit,
4 \$200.00.

5 (13) For substitution or amendment of a
6 security deposit, \$100.00.

7 (14) For certification of statutory
8 deposits, \$20.00.

9 (15) For filing a notice of intent to
10 relocate books and records pursuant to Article 1.28 of
11 this code, \$300.00.

12 (16) For filing a statement pursuant to
13 Section 5, Article 21.49-1 of this code, for the first
14 \$9,900,000.00 of the purchase price or consideration,
15 \$1,000.00.

16 (17) For filing a statement pursuant to
17 Section 5, Article 21.49-1 of this code, if the
18 purchase price or consideration exceeds
19 \$9,900,000.00, an additional \$500.00 for each
20 \$10,000,000.00 exceeding \$9,900,000.00, but not more
21 than \$10,000.00 total fee under this subdivision and
22 the preceding subdivision.

23 (18) For filing a registration statement
24 pursuant to Section 3, Article 21.49-1 of this code,
25 \$300.00.

26 (19) For filing for review pursuant to
27 Section 4, Article 21.49-1 or Article 22.15 of this
28 code, \$500.00.

29 (20) For filing of a direct reinsurance
30 agreement pursuant to Article 22.19 of this code,
31 \$300.00.

32 (21) For filing for approval of a merger
33 pursuant to Article 21.25 of this code, \$1,500.00.

34 (22) For filing for approval of
35 reinsurance pursuant to Article 21.26 of this code,
36 \$1,500.00.

37 (23) For filing of restated articles of
38 incorporation for domestic, foreign or alien
39 companies, \$500.00.

40 (24) For filing a joint control agreement,
41 \$100.00.

42 (25) For filing a substitution or
43 amendment to a joint control agreement, \$40.00.

44 (26) For filing a change of attorney in
45 fact, \$500.00.

46 Revisor's Note

47 Sections A(16) and (17), V.T.I.C. Article 4.07,
48 refer to the "purchase price or consideration" of a
49 transaction subject to Section 5, V.T.I.C. Article
50 21.49-1, revised as Subchapters D and E of Chapter 823
51 of this code. The revised law omits "purchase price"
52 because, in context, "purchase price" is included
53 within the meaning of "consideration." Also,
54 "consideration" is the term used in Chapter 823.

55 Revised Law

56 Sec. 202.052. FEES IMPOSED ON CERTAIN INSURERS. (a) The

1 department shall impose and the comptroller shall collect fees for
2 the use of the state from each authorized insurer writing a class of
3 insurance that may be written by an insurer operating under Chapter
4 841. The amount of the fees may not exceed:

5 (1) for valuing life insurance policies, and for each
6 \$1 million of insurance or fraction thereof \$10; and

7 (2) for filing the annual statement \$500.

8 (b) Subtitles A and B, Title 2, Tax Code, apply to a fee
9 collected under this section. (V.T.I.C. Art. 4.07, Sec. B.)

10 Source Law

11 B. For an authorized insurer writing a class of
12 insurance in this state that is subject to Chapter 3 of
13 this code, the Texas Department of Insurance shall
14 charge and the comptroller shall collect for the use of
15 the state fees in an amount to be determined by the
16 commissioner not to exceed the following:

17 (1) For valuing policies of life
18 insurance, and for each one million dollars of
19 insurance or fraction thereof, \$10.00.

20 (2) For filing the annual statement,
21 \$500.00.

22 The provisions of Subtitles A and B, Title 2, Tax
23 Code, and their subsequent amendments, apply to fees
24 collected by the comptroller under this section.

25 Revisor's Note

26 (1) Section B, V.T.I.C. Article 4.07, refers to
27 "an authorized insurer writing a class of insurance in
28 this state that is subject to Chapter 3 of this code."
29 The revised law substitutes a reference to "an
30 authorized insurer writing a class of insurance that
31 may be written by an insurer operating under Chapter
32 841." V.T.I.C. Chapter 3 generally relates to the
33 organization of life, health, and accident insurers
34 and the classes of insurance that are written by those
35 insurers. It is clear that the purpose of the reference
36 in Section B, V.T.I.C. Article 4.07, is to refer to
37 authorized insurers writing these classes of
38 insurance. The portion of V.T.I.C. Chapter 3 that
39 relates to the organization of those types of insurers
40 in this state is revised as Chapter 841 of this code.

1 It is therefore appropriate to refer to a class of
2 insurance that may be written by an insurer operating
3 under Chapter 841.

4 (2) Section B, V.T.I.C. Article 4.07, refers to
5 "Subtitles A and B, Title 2, Tax Code, and their
6 subsequent amendments." The revised law omits the
7 reference to "and their subsequent amendments" because
8 under Section 311.027, Government Code (Code
9 Construction Act), unless expressly provided
10 otherwise, a reference to a statute applies to all
11 reenactments, revisions, or amendments of the statute.

12 [Sections 202.053-202.100 reserved for expansion]

13 SUBCHAPTER C. DEPOSIT AND USE OF FEES

14 Revised Law

15 Sec. 202.101. DEPOSIT AND USE OF FEES GENERALLY. Amounts
16 collected under Section 202.051:

17 (1) shall be deposited to the credit of the Texas
18 Department of Insurance operating account; and

19 (2) may be appropriated only for the use and benefit of
20 the department as provided by the General Appropriations Act to pay
21 salaries and other expenses arising from and in connection with
22 investigations of violations of the insurance laws of this state
23 and the examination or licensing of insurers. (V.T.I.C. Art. 4.07,
24 Sec. F.)

25 Source Law

26 F. All fees collected by virtue of Section A of
27 this Article shall be deposited in the State Treasury
28 to the credit of the Texas Department of Insurance
29 operating fund and appropriated to the use and benefit
30 of the department to be used in the payment of salaries
31 and other expenses arising out of and in connection
32 with the examination of insurance companies and/or the
33 licensing of insurance companies and investigations of
34 violations of the insurance laws of this State in such
35 manner as provided in the general appropriation bill.

36 Revisor's Note

37 Section F, V.T.I.C. Article 4.07, refers to "the
38 Texas Department of Insurance operating fund." Under

1 the authority of Chapter 4, Acts of the 72nd
2 Legislature, 1st Called Session, 1991, the Texas
3 Department of Insurance operating fund was converted
4 to an account in the general revenue fund. The revised
5 law is drafted accordingly.

6 Revised Law

7 Sec. 202.102. DEPOSIT AND USE OF CERTAIN OTHER FEES.

8 Amounts collected by the comptroller under Section 202.052:

9 (1) shall be deposited to the credit of the general
10 revenue fund; and

11 (2) are available for appropriation to the department
12 as provided by the General Appropriations Act to pay salaries and
13 other expenses arising from investigations of violations of the
14 insurance laws of this state and the examination or licensing of
15 insurers. (V.T.I.C. Art. 4.07, Sec. G.)

16 Source Law

17 G. All fees collected by the comptroller under
18 Section B of this Article shall be deposited in the
19 general revenue fund. Those amounts are available for
20 appropriation to the Texas Department of Insurance for
21 its use in paying salaries and other expenses arising
22 out of the examination or licensing of insurance
23 companies and investigations of the violations of this
24 code or other insurance laws of this State as provided
25 by the General Appropriations Act.

26 CHAPTER 203. GENERAL PROVISIONS RELATING TO TAXES

27 Sec. 203.001. LIMITATION ON CERTAIN ADDITIONAL TAXES. 31

28 Sec. 203.002. TAX PAYMENT REQUIRED FOR CERTAIN CERTIFICATES;
29 UNREPORTED GROSS PREMIUM RECEIPTS 33

30 CHAPTER 203. GENERAL PROVISIONS RELATING TO TAXES

31 Revised Law

32 Sec. 203.001. LIMITATION ON CERTAIN ADDITIONAL TAXES. (a)

33 This section applies to:

34 (1) an insurer authorized to engage in the business of
35 insurance in this state other than an eligible surplus lines
36 insurer; and

37 (2) a health maintenance organization authorized to
38 engage in the business of a health maintenance organization in this

1 state.

2 (b) Except as otherwise provided by this code or the Labor
3 Code, an insurer or health maintenance organization subject to a
4 tax imposed by Chapter 4, 221, 222, 224, or 257 may not be required
5 to pay any additional tax imposed by this state or a county or
6 municipality in proportion to the insurer's or health maintenance
7 organization's gross premium receipts.

8 (c) Subsection (b) does not:

9 (1) limit the applicability of other taxes, fees, and
10 assessments imposed by this code; or

11 (2) prohibit the imposition and collection of state,
12 county, and municipal taxes on the property of insurers or health
13 maintenance organizations or state, county, and municipal taxes
14 imposed by other laws of this state, unless a specific exemption for
15 insurers or health maintenance organizations is provided in those
16 laws. (V.T.I.C. Art. 4.06.)

17 Source Law

18 Art. 4.06. (a) This chapter applies to
19 insurance organizations authorized to do insurance
20 business in this state other than eligible surplus
21 lines insurers.

22 (b) An insurance organization subject to a tax
23 levied by this chapter may not be required to pay any
24 additional tax in proportion to its gross premium
25 receipts levied by this state or any county or
26 municipality except as otherwise provided by this code
27 or the Labor Code. This exemption may not be construed
28 to limit the applicability of other taxes, fees, and
29 assessments that are imposed by other chapters of this
30 code. This exemption may not be construed to prohibit
31 the levy and collection of state, county, and
32 municipal taxes on the real and personal property of
33 insurance organizations, or the levy and collection of
34 state, county, and municipal taxes that are imposed by
35 other laws of this state, unless a specific exemption
36 for insurance organizations is provided in those laws.

37 Revisor's Note

38 (1) V.T.I.C. Article 4.06 states that the
39 "chapter," meaning V.T.I.C. Chapter 4, applies to
40 insurance organizations authorized to do insurance
41 business in this state other than eligible surplus
42 lines insurers. The revised law substitutes "section"
43 for "chapter" because it is clear from the context of

1 Article 4.06 and from other provisions of Chapter 4
2 that the applicability language was intended to affect
3 the applicability of Article 4.06 only and does not
4 affect the applicability of the other provisions of
5 Chapter 4.

6 (2) Section (a), V.T.I.C. Article 4.06, refers
7 to "insurance organizations authorized to do insurance
8 business in this state." Section (b) of the article
9 refers to "an insurance organization subject to a tax
10 levied by this chapter," meaning V.T.I.C. Chapter 4.
11 Many types of organizations pay taxes under Chapter 4,
12 including insurers and health maintenance
13 organizations. Although health maintenance
14 organizations are not "insurance" organizations and do
15 not engage in the business of "insurance," it is clear
16 that Article 4.06 is intended to apply to all
17 organizations subject to taxation under Chapter 4.
18 (Eligible surplus lines insurers do not pay a tax under
19 V.T.I.C. Chapter 4.) Therefore, the revised law
20 substitutes "insurer" and "health maintenance
21 organization" for "insurance organization" because in
22 context the terms are synonymous and the former terms
23 are more commonly used in this code.

24 (3) Section (b), V.T.I.C. Article 4.06, refers
25 to the imposition of taxes on "real and personal
26 property." The revised law omits the reference to
27 "real and personal" because under Section 311.005(4),
28 Government Code (Code Construction Act), "property"
29 includes both real and personal property. That
30 definition applies to the revised law.

31 Revised Law

32 Sec. 203.002. TAX PAYMENT REQUIRED FOR CERTAIN
33 CERTIFICATES; UNREPORTED GROSS PREMIUM RECEIPTS. (a) A life
34 insurance company may not receive a certificate of authority to

1 engage in the business of insurance in this state until all taxes
2 imposed under this code or another insurance law of this state are
3 paid.

4 (b) If the commissioner determines by examining a company or
5 by other means that the company's gross premium receipts in a year
6 exceed the amount reported by the company for that year, the
7 commissioner shall report that determination to the comptroller.
8 The comptroller shall institute a collection action as the
9 comptroller considers appropriate to collect taxes due on
10 unreported gross premium receipts. (V.T.I.C. Art. 4.05 (part).)

11 Source Law

12 Art. 4.05. No life insurance company shall
13 receive a certificate of authority to do business in
14 this State until all taxes imposed under this code or
15 another insurance law of this state are paid. If, upon
16 the examination of any company, or in any other manner,
17 the commissioner shall be informed that the gross
18 premium receipts of any year exceed in amount those
19 shown by the report thereof, theretofore made as above
20 provided, the commissioner shall report this fact to
21 the comptroller. The comptroller shall institute a
22 collection action, as the comptroller considers
23 appropriate in accordance with Subtitles A and B,
24 Title 2, Tax Code, and their subsequent amendments, to
25 collect taxes due on unreported gross premium
26 receipts. . . .

27 Revisor's Note

28 (1) V.T.I.C. Article 4.05 refers to gross
29 receipts of a company as shown by the report
30 "theretofore made as above provided." The revised law
31 omits the quoted language as unnecessary because
32 Chapter 685, Acts of the 73rd Legislature, Regular
33 Session, 1993, eliminated the reference to a report.

34 (2) V.T.I.C. Article 4.05 states that the
35 comptroller shall institute a collection action "in
36 accordance with Subtitles A and B, Title 2, Tax Code,
37 and their subsequent amendments." The revised law
38 omits the quoted language as unnecessary because
39 V.T.I.C. Article 1.04D, revised in relevant part as
40 Section 201.051 of this code, provides that, with
41 respect to insurance taxes, the comptroller has the

1 enforcement powers provided by those provisions of the
2 Tax Code.

3 (3) V.T.I.C. Article 4.05 requires that taxes be
4 deposited to the credit of the general revenue fund.
5 The revised law omits the provision as unnecessary
6 because Section 404.094, Government Code (State Funds
7 Reform Act), requires that all taxes collected or
8 received by a state agency be deposited to the credit
9 of the general revenue fund. The omitted law reads:

10 Art. 4.05. . . . The comptroller
11 shall deposit taxes collected under this
12 article to the credit of the general revenue
13 fund.

14 [Chapters 204-220 reserved for expansion]

15 SUBTITLE B. INSURANCE PREMIUM TAXES

16 CHAPTER 221. PROPERTY AND CASUALTY INSURANCE PREMIUM TAX

17 Sec. 221.001. APPLICABILITY OF CHAPTER. 35
18 Sec. 221.002. TAX IMPOSED; RATE 37
19 Sec. 221.003. TAX DUE DATES 41
20 Sec. 221.004. TAX REPORT 42
21 Sec. 221.005. CHANGE IN DUE DATES 43
22 Sec. 221.006. CREDIT FOR FEES PAID 43
23 Sec. 221.007. FAILURE TO PAY TAXES 43

24 CHAPTER 221. PROPERTY AND CASUALTY INSURANCE PREMIUM TAX

25 Revised Law

26 Sec. 221.001. APPLICABILITY OF CHAPTER. (a) This chapter
27 applies to an insurer, organization, or concern that receives gross
28 premiums subject to taxation under Section 221.002, including a
29 reciprocal or interinsurance exchange that elects to be subject to
30 taxation under this chapter in accordance with Section 224.003 and
31 a Lloyd's plan.

32 (b) This chapter does not apply to:

33 (1) a fraternal benefit society, including a fraternal
34 benefit society operating under Chapter 885;

35 (2) a group hospital service corporation operating

1 under Chapter 842;

2 (3) a stipulated premium company operating under
3 Chapter 884;

4 (4) a mutual assessment association, company, or
5 corporation regulated under Chapter 887; or

6 (5) a purely cooperative or mutual fire insurance
7 company carried on by its members solely for the protection of their
8 own property and not for profit, except as provided by Section
9 221.002(b)(13). (V.T.I.C. Art. 4.10, Secs. 1 (part), 3, 4(a).)

10 Source Law

11 Art. 4.10

12 Sec. 1. Every insurance carrier, including
13 Lloyd's and reciprocal exchanges and any other
14 organization or concern receiving gross premiums from
15

16 Sec. 3. This article shall not apply to
17 fraternal benefit associations or societies in this
18 state, to nonprofit group hospital service plans, to
19 stipulated premium companies nor to mutual assessment
20 associations, companies, or corporations regulated by
21 Chapter 14, Insurance Code, as amended.

22 Sec. 4. (a) Except as provided by Subsection
23 (b) of this section, this article shall not apply to
24 purely cooperative or mutual fire insurance companies
25 carried on by the members thereof solely for the
26 protection of their own property and not for profit.

27 Revisor's Note

28 (1) Section 1, V.T.I.C. Article 4.10, refers to
29 reciprocal exchanges. The revised law substitutes
30 "reciprocal or interinsurance exchange" because that
31 is the term normally used to describe such an insurer,
32 and Section 1, V.T.I.C. Article 4.11B, revised in this
33 code as Section 224.001, provides that "reciprocal
34 exchange" means a reciprocal or interinsurance
35 exchange. In addition, the revised law adds a
36 reference to a reciprocal or interinsurance exchange
37 "that elects to be subject to taxation under this
38 chapter" because under Section 2, V.T.I.C. Article
39 4.11C, revised in this code as Section 224.003, a
40 reciprocal or interinsurance exchange may elect to be
41 taxed under either Article 4.10 or Article 4.11B.

- 1 (2) ocean marine insurance;
- 2 (3) inland marine insurance;
- 3 (4) accident insurance;
- 4 (5) credit insurance;
- 5 (6) livestock insurance;
- 6 (7) fidelity insurance;
- 7 (8) guaranty insurance;
- 8 (9) surety insurance;
- 9 (10) casualty insurance;
- 10 (11) workers' compensation insurance;
- 11 (12) employers' liability insurance; and
- 12 (13) crop insurance written by a farm mutual insurance
- 13 company.

14 (c) The following premium receipts are not included in
15 determining an insurer's taxable premium receipts:

16 (1) premium receipts received from the business of
17 title insurance;

18 (2) premium receipts received from the business of
19 life insurance, personal accident insurance, life and accident
20 insurance, or health and accident insurance for profit, written by
21 a life insurance company, life and accident insurance company,
22 health and accident insurance company, or for mutual benefit or
23 protection in this state;

24 (3) premium receipts received from another authorized
25 insurer for reinsurance;

26 (4) returned premiums and dividends paid to
27 policyholders; and

28 (5) premiums excluded by another law of this state.

29 (d) In determining an insurer's taxable premium receipts,
30 an insurer is not entitled to a deduction for premiums paid for
31 reinsurance. (V.T.I.C. Art. 4.10, Secs. 1 (part), 2, 4(b), 5, 6(a)
32 (part), 10.)

33 Source Law

34 Sec. 1. [Every insurance carrier, including

1 Lloyd's and reciprocal exchanges and any other
2 organization or concern receiving gross premiums from]
3 the business of fire, marine, marine inland, accident,
4 credit, livestock, fidelity, guaranty, surety,
5 casualty, workers' compensation, employers' liability,
6 or any other kind or character of insurance, except
7 title insurance and except as provided in Sections 2,
8 3, and 4 of this article, shall pay to the comptroller
9 a tax upon such gross premium receipts as provided in
10 this article. Any such insurance carrier doing other
11 kinds of insurance business shall pay the tax levied
12 upon its gross premiums received from such other kinds
13 of business as provided in Articles 4.03 and 4.11 of
14 this code.

15 Sec. 2. This article shall not apply to premium
16 receipts received from the business of life insurance,
17 personal accident insurance, life and accident
18 insurance, or health and accident insurance for
19 profit, written by life insurance companies, life and
20 accident insurance companies, health and accident
21 insurance companies, or for mutual benefit or
22 protection of this state.

23 [Sec. 4]

24 (b) This article applies to crop insurance
25 premiums only written by a farm mutual insurance
26 company on or after January 1, 1994.

27 Sec. 5. Gross premium receipts referred to
28 herein are the total gross amount of premiums actually
29 written during the taxable year on each and every kind
30 of insurance or risk written upon property or risks
31 located in the State of Texas (except premium receipts
32 under Section 2), except premiums actually written by
33 other licensed companies for reinsurance, less return
34 premiums and dividends paid policyholders with no
35 deduction for premiums paid for reinsurance.

36 Sec. 6. (a) . . . each taxable year ending the
37 31st day of December

38 Sec. 10. There is imposed on each insurance
39 carrier subject to this article an annual tax equal to
40 1.6 percent of its premium receipts.

41 Revisor's Note

42 (1) Section 1, V.T.I.C. Article 4.10, refers to
43 "marine" and "marine inland" insurance. The revised
44 law substitutes "ocean marine" and "inland marine" for
45 "marine" and "marine inland" respectively, because, in
46 context, those are the proper names for those types of
47 insurance.

48 (2) Section 1, V.T.I.C. Article 4.10, requires
49 insurers to pay a premium tax "to the comptroller."
50 The revised law omits the reference to the comptroller
51 as unnecessary. Section (a), V.T.I.C. Article 1.04D,
52 revised in this code in Section 201.051(a), requires
53 the comptroller to collect taxes imposed under this

1 code.

2 (3) Section 1, V.T.I.C. Article 4.10, requires
3 an insurer "doing other kinds of insurance business"
4 to pay premium taxes on those types of business as
5 provided by "Articles 4.03 and 4.11 of this code,"
6 implying that a type of insurance not taxed under
7 V.T.I.C. Article 4.10 is taxed under V.T.I.C. Articles
8 4.03 and 4.11. The revised law omits the provision as
9 obsolete, unnecessary, and inaccurate. V.T.I.C.
10 Article 4.03, as enacted in 1951, states that Chapter 4
11 of the Insurance Code does not affect the obligation of
12 an insurance organization to make investments in Texas
13 securities as required by Article 3.33. V.T.I.C.
14 Article 3.33 was repealed by Chapter 332, Acts of the
15 58th Legislature, Regular Session, 1963. V.T.I.C.
16 Article 4.11, revised in this code as Chapter 222, by
17 its own terms imposes a premium tax on life, health,
18 and accident insurance. Other provisions of this code
19 impose a premium tax on "other kinds of insurance."
20 For example, V.T.I.C. Article 1.14-2, revised in this
21 code as Chapter 225, imposes a premium tax on surplus
22 lines insurance.

23 (4) Sections 1, 2, and 5, V.T.I.C. Article 4.10,
24 prescribe the types of premium receipts that are not
25 included in determining premium tax liability. The
26 revised law adds a reference to "premiums excluded by
27 another law of this state" for clarity because other
28 law, such as Section 6, V.T.I.C. Article 5.35-3,
29 provides that certain gross premiums are not subject
30 to taxation under Article 4.10.

31 (5) Section 4(b), V.T.I.C. Article 4.10, refers
32 to premiums written by a farm mutual insurance company
33 "on or after January 1, 1994." The revised law omits
34 the reference to the date as executed.

1 semiannual payment shall equal the tax which would be
2 owed on the aggregate of the gross premium receipts for
3 the two previous calendar quarters at the minimum tax
4 rate specified by law. The comptroller is authorized
5 to refund any overpayment of premium taxes that
6 results from the semiannual prepayment system herein
7 established.

8 Revisor's Note

9 Section 6(b), V.T.I.C. Article 4.10, requires
10 certain prepayments to be made "at the minimum tax rate
11 specified by law." Before 1999, the rate of the tax
12 imposed by V.T.I.C. Article 4.10 ranged from 1.6
13 percent to 3.5 percent depending on the amount of Texas
14 investments made by an insurer. The variable rates
15 were repealed by Chapter 852, Acts of the 76th
16 Legislature, Regular Session, 1999. Therefore, the
17 revised law omits the reference to the quoted
18 language.

19 Revised Law

20 Sec. 221.004. TAX REPORT. (a) An insurer liable for the
21 tax imposed by this chapter must file annually with the comptroller
22 a tax report on a form prescribed by the comptroller.

23 (b) The tax report is due on the date the tax is due under
24 Section 221.003(a). (V.T.I.C. Art. 4.10, Secs. 6(a) (part), 11.)

25 Source Law

26 Sec. 6. (a) A premium tax return for each
27 taxable year ending the 31st day of December preceding
28 shall be filed and . . . on or before the 1st day of
29 March of each year.

30 Sec. 11. Each insurance carrier which is liable
31 under this article for tax on premiums shall file a tax
32 return annually on forms prescribed by the
33 comptroller.

34 Revisor's Note

35 Sections 6(a) and 11, V.T.I.C. Article 4.10,
36 refer to a "tax return." The revised law substitutes
37 "tax report" for "tax return" because, in the context
38 of tax law, the terms are synonymous and the former is
39 more commonly used.

1 Revised Law

2 Sec. 221.005. CHANGE IN DUE DATES. (a) The comptroller by
3 rule may change the dates for reporting and paying taxes under this
4 chapter to improve operating efficiencies within the agency.

5 (b) A change by the comptroller in a reporting or payment
6 date must retain the system of semiannual prepayments prescribed by
7 Section 221.003. (V.T.I.C. Art. 4.10, Sec. 6(c).)

8 Source Law

9 (c) The comptroller by rule may change the dates
10 for reporting and payment of taxes to improve
11 operating efficiencies within the agency, so long as a
12 system of semiannual prepayment of taxes imposed by
13 this article is maintained.

14 Revised Law

15 Sec. 221.006. CREDIT FOR FEES PAID. (a) Except as
16 provided by Section 803.007, an insurer is entitled to a credit on
17 the amount of tax due under this chapter for all examination and
18 evaluation fees paid to or for the use of this state during the
19 calendar year for which the tax is due.

20 (b) The credit provided by this section is in addition to
21 any other credit authorized by statute. (V.T.I.C. Art. 4.10, Sec.
22 13.)

23 Source Law

24 Sec. 13. The amount of all examination and
25 evaluation fees paid in each taxable year to or for the
26 use of the State of Texas by an insurance carrier shall
27 be allowed as a credit on the amount of premium taxes
28 due under this article except as provided by Article
29 1.28 of this code. Any credit allowed by the
30 provisions of this section is in addition to any other
31 credits allowable by statute.

32 Revised Law

33 Sec. 221.007. FAILURE TO PAY TAXES. An insurer that fails
34 to pay all taxes imposed by this chapter is subject to Section
35 203.002. (V.T.I.C. Art. 4.10, Sec. 15.)

36 Source Law

37 Sec. 15. Any insurance carrier failing to pay
38 all taxes imposed by this article shall, in addition,
39 be subject to the provisions of Article 4.05,
40 Insurance Code.

1 Revisor's Note

2 Section 15, V.T.I.C. Article 4.10, states that an
3 insurer that fails to pay taxes shall, "in addition,"
4 be subject to V.T.I.C. Article 4.05, revised in this
5 code in Section 203.002. The revised law omits the
6 quoted language, which relates to the cumulative
7 effect of the section. An accepted principle of
8 statutory construction requires a statute to be given
9 cumulative effect with other statutes unless it
10 provides otherwise or unless the statutes are in
11 conflict. The general principle applies to this
12 revision.

13 CHAPTER 222. LIFE, HEALTH, AND ACCIDENT INSURANCE PREMIUM TAX

14 Sec. 222.001. APPLICABILITY OF CHAPTER. 44
15 Sec. 222.002. TAX IMPOSED 47
16 Sec. 222.003. TAX RATES 51
17 Sec. 222.004. TAX DUE DATES 58
18 Sec. 222.005. TAX REPORT 59
19 Sec. 222.006. CHANGE IN DUE DATES 60
20 Sec. 222.007. CREDIT FOR FEES PAID 60
21 Sec. 222.008. FAILURE TO PAY TAXES 61

22 CHAPTER 222. LIFE, HEALTH, AND ACCIDENT INSURANCE PREMIUM TAX

23 Revised Law

24 Sec. 222.001. APPLICABILITY OF CHAPTER. (a) This chapter
25 applies to:

26 (1) an insurer that receives gross premiums subject to
27 taxation under Section 222.002, including:

28 (A) a life, health, or accident insurance company
29 operating under Chapter 841 or 982;

30 (B) a group hospital service corporation
31 operating under Chapter 842;

32 (C) a general casualty company operating under
33 Chapter 861;

34 (D) a statewide mutual assessment company

1 operating under Chapter 881;

2 (E) a mutual life insurance company operating
3 under Chapter 882;

4 (F) a mutual insurance company operating under
5 Chapter 883;

6 (G) a stipulated premium company operating under
7 Chapter 884;

8 (H) a Lloyd's plan operating under Chapter 941;

9 (I) a reciprocal or interinsurance exchange
10 operating under Chapter 942; and

11 (J) a Mexican casualty insurance company
12 operating under Chapter 984; and

13 (2) a health maintenance organization operating under
14 Chapter 843 that receives gross revenues subject to taxation under
15 Section 222.002.

16 (b) This chapter does not apply to:

17 (1) a fraternal benefit society, including a fraternal
18 benefit society operating under Chapter 885;

19 (2) a local mutual aid association operating under
20 Chapter 886; or

21 (3) a society that limits its membership to one
22 occupation. (V.T.I.C. Art. 4.11, Secs. 1 (part), 2(a).)

23 Source Law

24 Art. 4.11

25 Sec. 1. Every insurance carrier receiving
26 premiums from the business

27 Sec. 2. The following definitions shall apply
28 to this article:

29 (a) "Carrier" means any insurer or group
30 hospital service plan transacting any such insurance
31 business in this state including companies operating
32 under the provisions of Chapters 3, 8, 11, 13, 15, 18,
33 19, 20, 20A, and 22 of the Insurance Code but excluding
34 local mutual aid associations, fraternal benefit
35 societies or associations, and societies that limit
36 their membership to one occupation.

37 Revisor's Note

38 (1) Section 1, V.T.I.C. Article 4.11, refers to
39 an "insurance carrier receiving premiums." Section
40 2(a), V.T.I.C. Article 4.11, defines "carrier" to mean

1 any "insurer or group hospital service plan
2 transacting any such insurance business." The revised
3 law substitutes "insurer" and "health maintenance
4 organization" for "carrier" because the definition of
5 "carrier" includes entities, such as health
6 maintenance organizations, that are not insurers. In
7 addition, health maintenance organizations do not
8 receive "premiums," but instead receive "revenues" for
9 the issuance of health maintenance certificates or
10 contracts. Therefore, the revised law adds a
11 reference to "revenues." Finally, the revised law
12 substitutes "gross premiums" for "premiums" and "gross
13 revenues" for "revenues" because the tax is based on
14 gross premiums and gross revenues. See Sections 5F,
15 5G, and 5H, V.T.I.C. Article 4.11, revised in this
16 chapter as Section 222.003. The substitution and
17 addition of those terms, as well as related changes
18 necessary to ensure consistency in terminology, are
19 made throughout this chapter.

20 (2) Section 2(a), V.T.I.C. Article 4.11, refers
21 to companies operating under "Chapters 3, 8, 11, 13,
22 15, 18, 19, 20, 20A, and 22 of the Insurance Code." For
23 clarity and consistency, the revised law provides the
24 names of the types of companies to which those chapters
25 apply.

26 (3) Section 2(a), V.T.I.C. Article 4.11, refers
27 to Chapter 3 of the Insurance Code. The relevant
28 portions of Chapter 3, relating to life, health, or
29 accident insurance companies, are revised in Chapters
30 841 and 982 of this code. The revised law is drafted
31 accordingly.

32 (4) Section 2(a), V.T.I.C. Article 4.11, refers
33 to Chapter 8 of the Insurance Code. The relevant
34 portions of Chapter 8, relating to general casualty

1 companies and Mexican casualty insurance companies,
2 are revised in Chapters 861 and 984 of this code. The
3 revised law is drafted accordingly.

4 (5) Section 2(a), V.T.I.C. Article 4.11, refers
5 to "local mutual aid associations" and "fraternal
6 benefit societies or associations." For clarity and
7 consistency, the revised law adds for those entities
8 references to the chapters of this code that provide
9 the authority for the operation of each entity.

10 (6) Section (a), V.T.I.C. Article 20A.33,
11 states that a health maintenance organization is an
12 "insurance organization" within the terms of V.T.I.C.
13 Article 4.11. The revised law omits this provision
14 because the term "insurance organization" is not used
15 in Article 4.11. In addition, Section 2(a), V.T.I.C.
16 Article 4.11, revised in this section, makes the
17 article applicable to a company operating under
18 Chapter 20A (health maintenance organizations) and
19 therefore is sufficient to include health maintenance
20 organizations. The omitted law reads:

21 (a) . . . For the purposes of
22 computing and collecting the tax herein
23 provided, a health maintenance organization
24 is an "insurance organization" within the
25 terms of Article 4.11, Insurance Code, as
26 amended.

27 Revised Law

28 Sec. 222.002. TAX IMPOSED. (a) An annual tax is imposed
29 on:

30 (1) each insurer that receives gross premiums subject
31 to taxation under this section; and

32 (2) each health maintenance organization that
33 receives gross revenues from the sale of health maintenance
34 certificates or contracts.

35 (b) Except as otherwise provided by this section, in
36 determining an insurer's taxable gross premiums or a health

1 maintenance organization's taxable gross revenues, the insurer or
2 health maintenance organization shall include the total gross
3 amounts of premiums, membership fees, assessments, dues, revenues,
4 and other considerations received by the insurer or health
5 maintenance organization in a calendar year from any kind of health
6 maintenance organization certificate or contract or insurance
7 policy or contract covering a person located in this state and
8 arising from the business of a health maintenance organization or
9 the business of life insurance, accident insurance, health
10 insurance, life and accident insurance, life and health insurance,
11 health and accident insurance, life, health, and accident
12 insurance, including variable life insurance, credit life
13 insurance, and credit accident and health insurance for profit or
14 otherwise or for mutual benefit or protection.

15 (c) The following are not included in determining an
16 insurer's taxable gross premiums or a health maintenance
17 organization's taxable gross revenues:

18 (1) returned premiums or revenues;

19 (2) dividends applied to purchase paid-up additions to
20 insurance or to shorten the endowment or premium payment period;

21 (3) premiums received from an insurer for reinsurance;

22 (4) premiums or revenues received from the treasury of
23 this state or the United States for insurance or benefits
24 contracted for by this state or the federal government:

25 (A) in accordance with or in furtherance of Title
26 2, Human Resources Code, or the Social Security Act (42 U.S.C.
27 Section 301 et seq.); or

28 (B) to provide welfare benefits to designated
29 welfare recipients;

30 (5) premiums or revenues paid on group health,
31 accident, and life policies or contracts in which the group covered
32 by the policy or contract consists of a single nonprofit trust
33 established to provide coverage primarily for employees of:

34 (A) a municipality, county, or hospital district

1 in this state; or

2 (B) a county or municipal hospital, without
3 regard to whether the employees are employees of the county or
4 municipality or of an entity operating the hospital on behalf of the
5 county or municipality; or

6 (6) premiums or revenues excluded by another law of
7 this state.

8 (d) For purposes of Subsection (c)(3), a stop-loss or excess
9 loss insurance policy issued to a health maintenance organization
10 is considered reinsurance. In determining an insurer's taxable
11 gross premiums or a health maintenance organization's taxable gross
12 revenues, an insurer or health maintenance organization is not
13 entitled to a deduction for premiums paid for reinsurance.
14 (V.T.I.C. Art. 4.11, Secs. 1, 2(c); Art. 20A.33, Sec. (a) (part);
15 New.)

16 Source Law

17 Art. 4.11

18 Sec. 1. Every insurance carrier receiving
19 premiums from the business of life insurance, accident
20 insurance, health insurance, life and accident
21 insurance, life and health insurance, health and
22 accident insurance, or life, health, and accident
23 insurance, including variable life insurance, credit
24 life insurance, and credit accident and health
25 insurance for profit or otherwise or for mutual
26 benefit or protection, in this state, shall pay to the
27 comptroller a tax upon its gross premiums as provided
28 in this article.

29 [Sec. 2]

30 (c) "Gross premiums" are the total gross
31 amount of all premiums, membership fees, assessments,
32 dues, and any other considerations for such insurance
33 received during the taxable year on each and every kind
34 of such insurance policy or contract covering persons
35 located in the State of Texas and arising from the
36 types of insurance specified in Section 1 of this
37 article, but deducting returned premiums, any
38 dividends applied to purchase paid-up additions to
39 insurance or to shorten the endowment or premium
40 payment period, and excluding those premiums received
41 from insurance carriers for reinsurance and there
42 shall be no deduction for premiums paid for
43 reinsurance. For purposes of this article, a
44 stop-loss or excess loss insurance policy issued to a
45 health maintenance organization, as defined under the
46 Texas Health Maintenance Organization Act (Chapter
47 20A, Vernon's Texas Insurance Code), shall be
48 considered reinsurance. Such gross premiums shall not
49 include premiums received from the Treasury of the
50 State of Texas or from the Treasury of the United

1 States for insurance contracted for by the state or
2 federal government for the purpose of providing
3 welfare benefits to designated welfare recipients or
4 for insurance contracted for by the state or federal
5 government in accordance with or in furtherance of the
6 provisions of Title 2, Human Resources Code, or the
7 Federal Social Security Act. The gross premiums
8 receipts so reported shall not include the amount of
9 premiums paid on group health, accident, and life
10 policies in which the group covered by the policy
11 consists of a single nonprofit trust established to
12 provide coverage primarily for employees of:

13 (1) a municipality, county, or
14 hospital district in this state; or

15 (2) a county or municipal hospital,
16 without regard to whether the employees are employees
17 of the county or municipality or another entity
18 operating the hospital on behalf of the county or
19 municipality.

20 [Art. 20A.33]

21 (a) . . . each such health maintenance
22 organization shall pay . . . for the gross amounts of
23 revenues collected for the issuance of health
24 maintenance certificates or contracts

25 Revisor's Note

26 (1) Section 1, V.T.I.C. Article 4.11, requires
27 insurers and health maintenance organizations to pay a
28 premium tax "to the comptroller." The revised law
29 omits the reference to the comptroller as unnecessary.
30 Section (a), V.T.I.C. Article 1.04D, revised in this
31 code in Section 201.051(a), requires the comptroller
32 to collect taxes imposed under this code.

33 (2) Section 2(c), V.T.I.C. Article 4.11, refers
34 to a "taxable year." The revised law substitutes
35 "calendar year" for "taxable year" because Section
36 2(f), V.T.I.C. Article 4.11, revised in this chapter
37 in Section 222.003, defines "tax year" to mean a
38 calendar year.

39 (3) Section 2(c), V.T.I.C. Article 4.11,
40 prescribes the types of gross premiums that are not
41 included in determining premium tax liability. The
42 revised law adds a reference to "gross revenues" for
43 the reason stated in Revisor's Note (1) to Section
44 222.001. The revised law also adds a reference to
45 "premiums or revenues excluded by another law of this

1 state" for clarity because other law, such as Section
2 10(b), V.T.I.C. Article 3.50-2, and Section 4,
3 V.T.I.C. Article 3.71, revised in this code as
4 Sections 1551.012 and 1505.008, respectively,
5 provides that certain premiums and revenues are not
6 subject to premium taxes.

7 Revised Law

8 Sec. 222.003. TAX RATES. (a) Except as provided by
9 Subsection (b), the rate of the tax imposed by this chapter on an
10 insurer is 1.75 percent of the insurer's taxable gross premiums
11 received during a calendar year.

12 (b) The rate of the tax imposed by this chapter on an insurer
13 that receives taxable gross premiums from the business of life
14 insurance is:

15 (1) 0.875 percent of the first \$450,000 of taxable
16 gross premiums received during a calendar year from the business of
17 life insurance; and

18 (2) 1.75 percent of the remaining taxable gross
19 premiums received during that calendar year from the business of
20 life insurance.

21 (c) The rate of the tax imposed by this chapter on a health
22 maintenance organization is:

23 (1) 0.875 percent of the first \$450,000 of taxable
24 gross revenues received during a calendar year for the issuance of
25 health maintenance certificates or contracts; and

26 (2) 1.75 percent of the remaining taxable gross
27 revenues received during that calendar year for the issuance of
28 health maintenance certificates or contracts. (V.T.I.C.
29 Art. 4.11, Secs. 2(f), 5F, 5G, 5H; Art. 20A.33, Sec. (a) (part).)

30 Source Law

31 [Sec. 2]

32 (f) "Tax year" is the calendar year,
33 January 1 to December 31.

34 Sec. 5F. (a) Except for gross premiums on life
35 insurance taxed under Section 5G of this article and
36 gross revenues of health maintenance organizations

1 taxed under Subsection (b) of this section and Section
2 5H of this article, beginning with tax year 1995, there
3 is imposed on each insurance carrier an annual tax
4 equal to 1.75 percent of its gross premiums.

5 (b) Beginning with tax year 1995, there is
6 imposed on each health maintenance organization
7 operating under the Texas Health Maintenance
8 Organization Act (Chapter 20A, Vernon's Texas
9 Insurance Code) an annual tax equal to 1.75 percent of
10 its gross amount of its revenues collected for
11 issuance of health maintenance certificates or
12 contracts.

13 Sec. 5G. There is imposed on each insurance
14 carrier a tax on the first \$450,000 of its gross
15 premiums on life insurance at a rate equal to one-half
16 of the rate paid by that insurance carrier under
17 Section 5, 5A, 5B, 5C, 5D, 5E, or 5F of this article, as
18 appropriate, for the same tax year.

19 Sec. 5H. There is imposed on each health
20 maintenance organization a tax on the first \$450,000
21 of its gross amount of revenues collected for issuance
22 of health maintenance certificates or contracts at a
23 rate equal to one-half of the rate paid by that health
24 maintenance organization under Section 5, 5A, 5B, 5C,
25 5D, 5E, or 5F of this article, as appropriate, for the
26 same tax year.

27 [Art. 20A.33]

28 (a) . . . each such health maintenance
29 organization shall pay an annual tax for the gross
30 amounts of revenues collected for the issuance of
31 health maintenance certificates or contracts at the
32 rate provided by Article 4.11, Insurance Code, as
33 amended. . . .

34 Revisor's Note

35 (1) Sections 5, 5A, 5B, 5C, 5D, and 5E, V.T.I.C.
36 Article 4.11, prescribe the tax rates for 1989, 1990,
37 1991, 1992, 1993, and 1994, respectively. The revised
38 law omits those provisions because they have expired.

39 The omitted law reads:

40 Sec. 5. (a) Except for gross
41 premiums on life insurance taxed under
42 Section 5G of this article and gross
43 revenues of health maintenance
44 organizations taxed under Subsection (b) of
45 this section and Section 5H of this article,
46 for the 1989 tax year and tax years
47 preceding the 1989 tax year, there is
48 imposed on each insurance carrier an annual
49 tax equal to 2.5 percent of its gross
50 premiums. Any insurance carrier may
51 qualify for a tax rate lower than the 2.5
52 percent imposed by this article. Such
53 qualification for a lower rate can be
54 accomplished in the following manner:

55 (1) if such insurance carrier
56 for the year ending December 31 preceding
57 owned Texas investments with admitted asset
58 value of less than or equal to 100 percent
59 but more than or equal to 90 percent of
60 similar investments such insurance carrier

1 owned in the comparison state as herein
2 defined, the tax imposed shall be equal to
3 1.8 percent of its gross premiums; or

4 (2) if such insurance carrier
5 for the year ending December 31 preceding
6 owned Texas investments with admitted asset
7 value of more than 100 percent of the amount
8 such insurance carrier owned in the
9 comparison state in similar investments as
10 herein defined, the tax imposed shall be
11 equal to 1.10 percent of its gross premiums.

12 (b) Except for gross revenues taxed
13 under Section 5H of this article, for the
14 tax years specified by Subsection (a) of
15 this section, there is imposed on each
16 health maintenance organization operating
17 under the Texas Health Maintenance
18 Organization Act (Chapter 20A, Vernon's
19 Texas Insurance Code) an annual tax on its
20 gross amount of revenues collected for
21 issuance of health maintenance certificates
22 or contracts at the rate provided by
23 Subsection (a)(2) of this section.

24 Sec. 5A. (a) Except for gross
25 premiums on life insurance taxed under
26 Section 5G of this article and gross
27 revenues of health maintenance
28 organizations taxed under Subsection (b) of
29 this section and Article 5H of this article,
30 for the 1990 tax year, there is imposed on
31 each insurance carrier an annual tax equal
32 to 2.4 percent of its gross premiums. Any
33 insurance carrier may qualify for a tax rate
34 lower than the 2.4 percent imposed by this
35 article. Such qualification for a lower
36 rate can be accomplished in the following
37 manner:

38 (1) if such insurance carrier
39 for the year ending December 31 preceding
40 owned Texas investments with admitted asset
41 value of less than or equal to 100 percent
42 but more than or equal to 90 percent of
43 similar investments such insurance carrier
44 owned in the comparison state as herein
45 defined, the tax imposed shall be equal to
46 1.85 percent of its gross premiums; or

47 (2) if such insurance carrier
48 for the year ending December 31 preceding
49 owned Texas investments with admitted asset
50 value of more than 100 percent of the amount
51 such insurance carrier owned in the
52 comparison state in similar investments as
53 herein defined, the tax imposed shall be
54 equal to 1.3 percent of its gross premiums.

55 (b) Except for gross revenues taxed
56 under Section 5H of this article, for the
57 tax year specified by Subsection (a) of this
58 section, there is imposed on each health
59 maintenance organization operating under
60 the Texas Health Maintenance Organization
61 Act (Chapter 20A, Vernon's Texas Insurance
62 Code) an annual tax on its gross amount of
63 revenues collected for issuance of health
64 maintenance certificates or contracts at
65 the rate provided by Subsection (a)(2) of
66 this section.

67 Sec. 5B. (a) Except for gross
68 premiums on life insurance taxed under

1 Section 5G of this article and gross
2 revenues of health maintenance
3 organizations taxed under Subsection (b) of
4 this section and Section 5H of this article,
5 for the 1991 tax year, there is imposed on
6 each insurance carrier an annual tax equal
7 to 2.3 percent of its gross premiums. Any
8 insurance carrier may qualify for a tax rate
9 lower than the 2.3 percent imposed by this
10 article. Such qualification for a lower
11 rate can be accomplished in the following
12 manner:

13 (1) if such insurance carrier
14 for the year ending December 31 preceding
15 owned Texas investments with admitted asset
16 value of less than or equal to 100 percent
17 but more than or equal to 90 percent of
18 similar investments such insurance carrier
19 owned in the comparison state as herein
20 defined, the tax imposed shall be equal to
21 1.85 percent of its gross premiums; or

22 (2) if such insurance carrier
23 for the year ending December 31 preceding
24 owned Texas investments with admitted asset
25 value of more than 100 percent of the amount
26 such insurance carrier owned in the
27 comparison state in similar investments as
28 herein defined, the tax imposed shall be
29 equal to 1.4 percent of its gross premiums.

30 (b) Except for gross revenues taxed
31 under Section 5H of this article, for the
32 tax year specified by Subsection (a) of this
33 section, there is imposed on each health
34 maintenance organization operating under
35 the Texas Health Maintenance Organization
36 Act (Chapter 20A, Vernon's Texas Insurance
37 Code) an annual tax on its gross amount of
38 revenues collected for issuance of health
39 maintenance certificates or contracts at
40 the rate provided by Subsection (a)(2) of
41 this section.

42 Sec. 5C. (a) Except for gross
43 premiums on life insurance taxed under
44 Section 5G of this article and gross
45 revenues of health maintenance
46 organizations taxed under Subsection (b) of
47 this section and Section 5H of this article,
48 for the 1992 tax year, there is imposed on
49 each insurance carrier an annual tax equal
50 to 2.2 percent of its gross premiums. Any
51 insurance carrier may qualify for a tax rate
52 lower than the 2.2 percent imposed by this
53 article. Such qualification for a lower
54 rate can be accomplished in the following
55 manner:

56 (1) if such insurance carrier
57 for the year ending December 31 preceding
58 owned Texas investments with admitted asset
59 value of less than or equal to 100 percent
60 but more than or equal to 90 percent of
61 similar investments such insurance carrier
62 owned in the comparison state as herein
63 defined, the tax imposed shall be equal to
64 1.85 percent of its gross premiums; or

65 (2) if such insurance carrier
66 for the year ending December 31 preceding
67 owned Texas investments with admitted asset
68 value of more than 100 percent of the amount

1 such insurance carrier owned in the
2 comparison state in similar investments as
3 herein defined, the tax imposed shall be
4 equal to 1.5 percent of its gross premiums.

5 (b) Except for gross revenues taxed
6 under Section 5H of this article, for the
7 tax year specified by Subsection (a) of this
8 section, there is imposed on each health
9 maintenance organization operating under
10 the Texas Health Maintenance Organization
11 Act (Chapter 20A, Vernon's Texas Insurance
12 Code) an annual tax on its gross amount of
13 revenues collected for issuance of health
14 maintenance certificates or contracts at
15 the rate provided by Subsection (a)(2) of
16 this section.

17 Sec. 5D. (a) Except for gross
18 premiums on life insurance taxed under
19 Section 5G of this article and gross
20 revenues of health maintenance
21 organizations taxed under Subsection (b) of
22 this section and Section 5H of this article,
23 for the 1993 tax year, there is imposed on
24 each insurance carrier an annual tax equal
25 to 2.1 percent of its gross premiums. Any
26 insurance carrier may qualify for a tax rate
27 lower than the 2.1 percent imposed by this
28 article. Such qualification for a lower
29 rate can be accomplished in the following
30 manner:

31 (1) if such insurance carrier
32 for the year ending December 31 preceding
33 owned Texas investments with admitted asset
34 value of less than or equal to 100 percent
35 but more than or equal to 90 percent of
36 similar investments such insurance carrier
37 owned in the comparison state as herein
38 defined, the tax imposed shall be equal to
39 1.85 percent of its gross premiums; or

40 (2) if such insurance carrier
41 for the year ending December 31 preceding
42 owned Texas investments with admitted asset
43 value of more than 100 percent of the amount
44 such insurance carrier owned in the
45 comparison state in similar investments as
46 herein defined, the tax imposed shall be
47 equal to 1.6 percent of its gross premiums.

48 (b) Except for gross revenues taxed
49 under Section 5H of this article, for the
50 tax year specified by Subsection (a) of this
51 section, there is imposed on each health
52 maintenance organization operating under
53 the Texas Health Maintenance Organization
54 Act (Chapter 20A, Vernon's Texas Insurance
55 Code) an annual tax on its gross amount of
56 revenues collected for issuance of health
57 maintenance certificates or contracts at
58 the rate provided by Subsection (a)(2) of
59 this section.

60 Sec. 5E. (a) Except for gross
61 premiums on life insurance taxed under
62 Section 5G of this article and gross
63 revenues of health maintenance
64 organizations taxed under Subsection (b) of
65 this section and Section 5H of this article,
66 for the 1994 tax year, there is imposed on
67 each insurance carrier an annual tax equal
68 to 2.0 percent of its gross premiums. Any

1 insurance carrier may qualify for a tax rate
2 lower than the 2.0 percent imposed by this
3 article. Such qualification for a lower
4 rate can be accomplished in the following
5 manner:

6 (1) if such insurance carrier
7 for the year ending December 31 preceding
8 owned Texas investments with admitted asset
9 value of less than or equal to 100 percent
10 but more than or equal to 90 percent of
11 similar investments such insurance carrier
12 owned in the comparison state as herein
13 defined, the tax imposed shall be equal to
14 1.85 percent of its gross premiums; or

15 (2) if such insurance carrier
16 for the year ending December 31 preceding
17 owned Texas investments with admitted asset
18 value of more than 100 percent of the amount
19 such insurance carrier owned in the
20 comparison state in similar investments as
21 herein defined, the tax imposed shall be
22 equal to 1.7 percent of its gross premiums.

23 (b) Except for gross revenues taxed
24 under Section 5H of this article, there is
25 imposed on each health maintenance
26 organization operating under the Texas
27 Health Maintenance Organization Act
28 (Chapter 20A, Vernon's Texas Insurance
29 Code) an annual tax on its gross amount of
30 revenues collected for issuance of health
31 maintenance certificates or contracts at
32 the rate provided by Subsection (a)(2) of
33 this section.

34 (2) Sections 2(b), (d), (e), and (g), V.T.I.C.
35 Article 4.11, define "comparison state," "similar
36 investments," "tax rate," and "Texas investments." In
37 addition, Section 4, V.T.I.C. Article 4.11, provides a
38 method for determining an insurer's or health
39 maintenance organization's "Texas investments." The
40 revised law omits those provisions because they apply
41 only to the computation of taxes for the tax years 1989
42 through 1994. The omitted law reads:

43 [Sec. 2. The following definitions
44 shall apply to this article:]

45 (b) "Comparison state" is
46 defined as the state other than Texas in
47 which a carrier owns the largest amount of
48 similar investments to those qualified and
49 enumerated in Section 4 of this article.

50 (d) "Similar investments" means
51 the same character of property and
52 investments described in Section 4 of this
53 article, located in a state other than Texas
54 and originating and existing with the same
55 relationship to such state as the location
56 and relationship of such property is to the
57 State of Texas.

1 (e) "Tax rate" means that rate
2 specified in Section 5 of this article as
3 determined by the carrier's Texas
4 investment comparison state similar
5 investments asset ratio.

6 (g) "Texas investments" are
7 those investments described and enumerated
8 in Section 4 of this article.

9 Sec. 4. (a) For the purposes of this
10 article, Texas investments and similar
11 investments of comparison states are to be
12 attributed as follows:

13 (1) bonds and other obligations
14 of the United States are to be allocated
15 proportionately to each state in the same
16 ratio as its gross direct premium income is
17 received from each state;

18 (2) mortgage loans are to be
19 allocated to the state in which the real
20 property securing the loan is located;

21 (3) bonds and other obligations
22 of governmental units are to be allocated to
23 the state in which such units are located;

24 (4) corporate stocks, bonds, or
25 other obligations are to be allocated to the
26 state of domicile of such corporation;

27 (5) deposits, loans to, or
28 investments in any bank, savings and loan,
29 or other financial institution shall be
30 allocated to the state in which such
31 institution is located; the amount of
32 "demand deposits" in such institution for
33 the purposes of this article shall be the
34 average of each of the 12 months' ending
35 balances as determined from the carrier's
36 books and records;

37 (6) policy loans shall be
38 allocated to the policy address of the
39 policyholder;

40 (7) collateral loans shall be
41 allocated to the state of address of the
42 borrower; and

43 (8) real property, or any
44 interest therein, shall be allocated to the
45 state in which it is located.

46 (b) The value of loans under
47 Subsections (a)(2), (6), and (7) of this
48 section is determined by dividing the sum of
49 the unpaid principal balance of those loans
50 as shown on the books of the insurance
51 carrier at the close of each calendar
52 quarter by four.

53 (c) The value of stocks, bonds, and
54 other obligations of governmental units and
55 corporations under Subsections (a)(1), (3),
56 and (4) of this section is determined by
57 dividing the sum of the amortized value of
58 those investments as shown on the books of
59 the insurance carrier at the close of each
60 calendar quarter by four.

61 (d) The value of real property and
62 any interest in real property under
63 Subsection (a)(8) of this section is
64 determined by dividing the sum of the value
65 of that real estate and other interests in
66 real property as shown on the books of the

1 insurance carrier at the close of each
2 calendar quarter by four.

3 Revised Law

4 Sec. 222.004. TAX DUE DATES. (a) The total tax imposed by
5 this chapter is due and payable not later than:

6 (1) March 1 after the end of the calendar year for
7 which the tax is due;

8 (2) the date the annual statement for the insurer or
9 health maintenance organization is required to be filed with the
10 commissioner after the end of the calendar year for which the tax is
11 due; or

12 (3) another date prescribed by the comptroller.

13 (b) An insurer or health maintenance organization that had a
14 net tax liability for the previous calendar year of more than \$1,000
15 shall make semiannual prepayments of tax on March 1 and August 1.
16 The tax paid on each date must be equal to 50 percent of the total
17 amount of tax the insurer or health maintenance organization paid
18 under this chapter for the previous calendar year. If the insurer
19 or health maintenance organization did not pay a tax under this
20 chapter during the previous calendar year, the tax paid on each date
21 must be equal to the tax that would be owed on the aggregate of the
22 taxable gross premiums or taxable gross revenues for the two
23 previous calendar quarters.

24 (c) The comptroller may refund any overpayment of taxes that
25 results from the semiannual prepayment system prescribed by this
26 section. (V.T.I.C. Art. 4.11, Secs. 3 (part), 13(a).)

27 Source Law

28 Sec. 3. . . . for each tax year ending the 31st
29 day of December preceding . . . the total amount of the
30 tax due under this article shall be paid on or before
31 either March 1 of each year, the date the annual
32 statement for such carrier is required to be filed with
33 the commissioner, or another date prescribed by the
34 comptroller.

35 Sec. 13. (a) A semiannual prepayment of
36 premium tax must be made on March 1 and August 1 by all
37 insurers with net tax liability for the previous
38 calendar year in excess of \$1,000. The tax paid on each
39 date must equal one-half of the total premium tax paid
40 for the previous calendar year. Should no premium tax
41 have been paid during the previous calendar year, the

1 semiannual payment shall equal the tax which would be
2 owed on the aggregate of the gross premium receipts for
3 the two previous calendar quarters at the minimum tax
4 rate specified by law. The comptroller is authorized
5 to refund any overpayment of premium taxes that
6 results from the semiannual prepayment system herein
7 established.

8 Revisor's Note

9 Section 13(a), V.T.I.C. Article 4.11, requires
10 certain prepayments to be made "at the minimum tax rate
11 specified by law." Before 1995, the tax imposed by
12 V.T.I.C. Article 4.11 was imposed at different rates
13 depending on the amount of Texas investments made by
14 the insurer or health maintenance organization. The
15 variable rates were phased out effective January 1,
16 1995. Therefore, the revised law omits the quoted
17 language.

18 Revised Law

19 Sec. 222.005. TAX REPORT. (a) An insurer or health
20 maintenance organization liable for the tax imposed by this chapter
21 must file annually with the comptroller a tax report on a form
22 prescribed by the comptroller.

23 (b) The tax report is due on the date the tax is due under
24 Section 222.004(a).

25 (c) The comptroller may require the insurer or health
26 maintenance organization to file any additional relevant
27 information that is reasonably necessary to verify the amount of
28 tax due. (V.T.I.C. Art. 4.11, Secs. 3 (part), 6.)

29 Source Law

30 Sec. 3. A premium tax return for each tax year
31 ending the 31st day of December preceding shall be
32 filed and . . . on or before either March 1 of each
33 year, the date the annual statement for such carrier is
34 required to be filed with the commissioner, or another
35 date prescribed by the comptroller.

36 Sec. 6. Each insurance carrier which is liable
37 under this article for tax on premiums shall file a tax
38 return annually on forms prescribed by the
39 comptroller. The comptroller may require such carrier
40 to file any relevant additional information reasonably
41 necessary to verify the amount of tax due.

1 Revisor's Note

2 (1) Section 3, V.T.I.C. Article 4.11, refers to
3 a "tax return." The revised law substitutes "tax
4 report" for "tax return" because, in the context of tax
5 law, the terms are synonymous and the former is more
6 commonly used.

7 (2) Section (a), V.T.I.C. Article 20A.33,
8 requires a health maintenance organization to file an
9 annual statement before March 1 that shows the gross
10 amount of revenues collected during the previous year.
11 The revised law omits this provision as unnecessary
12 because Section 843.155 of this code requires each
13 health maintenance organization to file such an annual
14 statement. The omitted law reads:

15 Art. 20A.33

16 (a) Each health maintenance
17 organization shall on or before the first
18 day of March of each year file its annual
19 statement showing the gross amount of
20 revenues collected during the year ending
21 December 31 preceding, and

22 Revised Law

23 Sec. 222.006. CHANGE IN DUE DATES. (a) The comptroller by
24 rule may change the dates for reporting and paying taxes under this
25 chapter to improve operating efficiencies within the agency.

26 (b) A change by the comptroller in a reporting or payment
27 date must retain the system of semiannual prepayments prescribed by
28 Section 222.004. (V.T.I.C. Art. 4.11, Sec. 13(b).)

29 Source Law

30 (b) The comptroller by rule may change the dates
31 for reporting and payment of taxes to improve
32 operating efficiencies within the agency, so long as a
33 system of semiannual prepayment of taxes imposed by
34 this article is maintained.

35 Revised Law

36 Sec. 222.007. CREDIT FOR FEES PAID. (a) Except as
37 provided by Section 803.007, an insurer or health maintenance
38 organization is entitled to a credit on the amount of tax due under
39 this chapter for all examination and valuation fees paid to or for

1 the use of this state during the calendar year for which the tax is
2 due.

3 (b) The credit provided by this section is in addition to
4 any other credit authorized by statute. (V.T.I.C. Art. 4.11, Sec.
5 8.)

6 Source Law

7 Sec. 8. The amount of all examination and
8 valuation fees paid during each tax year to or for the
9 use of the State of Texas by an insurance carrier shall
10 be allowed as a credit on the amount of premium taxes
11 due under this article except as provided by Article
12 1.28 of this code. Any credit allowed by the provisions
13 of this section is in addition to any other credits
14 allowable by statute.

15 Revised Law

16 Sec. 222.008. FAILURE TO PAY TAXES. An insurer or health
17 maintenance organization that fails to pay all taxes imposed by
18 this chapter is subject to Section 203.002. (V.T.I.C. Art. 4.11,
19 Sec. 10.)

20 Source Law

21 Sec. 10. Any insurance carrier failing to pay
22 all taxes imposed by this article shall be subject to
23 the provisions of Article 4.05, Insurance Code, and of
24 Subtitles A and B, Title 2, Tax Code, and their
25 subsequent amendments.

26 Revisor's Note

27 Section 10, V.T.I.C. Article 4.11, states that an
28 insurer or health maintenance organization that fails
29 to pay all taxes is subject to the provisions of
30 "Subtitles A and B, Title 2, Tax Code, and their
31 subsequent amendments." The revised law omits the
32 quoted language as unnecessary. The reference to
33 Subtitles A and B is omitted because Section 111.0022,
34 Tax Code, states that Subtitles A and B apply to the
35 administration, collection, and enforcement of any tax
36 the comptroller is required or authorized to collect
37 under a law other than the Tax Code. The reference to
38 "subsequent amendments" is omitted because under
39 Section 311.027, Government Code (Code Construction

1 Act), unless expressly provided otherwise, a reference
2 to a statute applies to all reenactments, revisions,
3 or amendments of the statute.

4 Revisor's Note
5 (End of Chapter)

6 Section (c), V.T.I.C. Article 20A.33, states that
7 V.T.I.C. Articles 4.13, 4.14, and 4.15 apply to
8 certain health maintenance organizations. The revised
9 law omits this section as obsolete because those
10 articles were repealed by Chapter 685, Acts of the 73rd
11 Legislature, Regular Session, 1993. The omitted law
12 reads:

13 (c) Each health maintenance
14 organization covered by Subsection (a) of
15 this section shall be subject to Articles
16 4.13, 4.14, and 4.15, Insurance Code.

17 CHAPTER 223. TITLE INSURANCE PREMIUM TAX

18	Sec. 223.001.	APPLICABILITY OF CERTAIN DEFINITIONS.	62
19	Sec. 223.002.	APPLICABILITY OF CHAPTER.	63
20	Sec. 223.003.	TAX IMPOSED	63
21	Sec. 223.004.	LIMITATION ON CERTAIN ADDITIONAL TAXES.	65
22	Sec. 223.005.	PREMIUMS PAID TO TITLE INSURANCE AGENT.	66
23	Sec. 223.006.	TAX DUE DATES	67
24	Sec. 223.007.	TAX REPORTS	68
25	Sec. 223.008.	RULES.	68
26	Sec. 223.009.	CREDIT FOR FEES PAID	69
27	Sec. 223.010.	FAILURE TO PAY TAXES	70
28	Sec. 223.011.	DISPOSITION OF REVENUE	70

29 CHAPTER 223. TITLE INSURANCE PREMIUM TAX

30 Revised Law

31 Sec. 223.001. APPLICABILITY OF CERTAIN DEFINITIONS. In
32 this chapter, a term defined by Chapter 2501 has the meaning
33 assigned by that chapter. (New.)

34 Revisor's Note

35 This chapter is derived from V.T.I.C. Article
36 9.59, part of the Texas Title Insurance Act. The

1 premiums, a title insurance company is not entitled to a deduction
2 for premiums paid for reinsurance. (V.T.I.C. Art. 9.59, Secs. 1
3 (part), 2, 3(a) (part), 4; New.)

4 Source Law

5 Sec. 1. [Each title insurance company receiving
6 premiums] from the business of title insurance shall
7 pay to the comptroller a tax on those premiums as
8 provided in this article.

9 Sec. 2. In this article premium means the total
10 amount of premiums received for the taxable year on
11 title insurance written on property located in this
12 state except premiums received from other licensed
13 title insurance companies for reinsurance, less return
14 premiums paid policyholders with no deduction for
15 premiums paid for reinsurance.

16 Sec. 3. (a) . . . each taxable year ending on
17 December 31

18 Sec. 4. There is imposed on all premium on title
19 insurance an annual tax equal to 1.35 percent.

20 Revisor's Note

21 (1) Section 1, V.T.I.C. Article 9.59, refers to
22 a title insurance company receiving premiums from "the
23 business of title insurance." Section (b), V.T.I.C.
24 Article 9.02, revised in this code in Section
25 2501.005, specifies the activities that constitute
26 engaging in the business of title insurance. The
27 revised law adds a reference to that section for the
28 convenience of the reader.

29 (2) Section 1, V.T.I.C. Article 9.59, requires
30 title insurance companies to pay a premium tax "to the
31 comptroller." The revised law omits the reference to
32 the comptroller as unnecessary. Section (a), V.T.I.C.
33 Article 1.04D, revised in this code in Section
34 201.051(a), requires the comptroller to collect taxes
35 imposed under this code.

36 (3) Section 2, V.T.I.C. Article 9.59, refers to
37 a "taxable year" and Section 3, V.T.I.C. Article 9.59,
38 refers to a "taxable year ending on December 31."
39 Throughout this chapter, the revised law substitutes
40 "calendar year" for "taxable year" because the terms
41 are synonymous and the former is more accurate.

1 exemption for title insurance companies or title insurance agents
2 is provided in those laws. (V.T.I.C. Art. 9.59, Sec. 8(a).)

3 Source Law

4 Sec. 8. (a) Title insurance companies and
5 title insurance agents subject to the tax levied by
6 this article may not be required to pay any additional
7 tax in proportion to their gross premium receipts
8 levied by this state or any county or municipality
9 except as otherwise provided by this code and the Labor
10 Code. This exemption may not be construed to limit the
11 applicability of other taxes, fees, and assessments
12 that are imposed by other chapters of this code. This
13 exemption may not be construed to prohibit the levy and
14 collection of state, county, and municipal taxes on
15 the real and personal property of title insurance
16 companies and title insurance agents, or the levy and
17 collection of state, county, and municipal taxes that
18 are imposed by other laws of this state, unless a
19 specific exemption for title insurance companies and
20 title insurance agents is provided in those laws.

21 Revisor's Note

22 Section 8(a), V.T.I.C. Article 9.59, refers to
23 the imposition of taxes on "real and personal
24 property." The revised law omits the reference to
25 "real and personal" because under Section 311.005(4),
26 Government Code (Code Construction Act), "property"
27 includes both real and personal property. That
28 definition applies to the revised law.

29 Revised Law

30 Sec. 223.005. PREMIUMS PAID TO TITLE INSURANCE AGENT. (a)
31 Premiums received from the business of title insurance are subject
32 to the tax under this chapter regardless of whether paid to a title
33 insurance company or retained by a title insurance agent, with the
34 tax being in lieu of the tax on the premiums retained by a title
35 insurance agent.

36 (b) The state facilitates the collection of the premium tax
37 on the premiums retained by a title insurance agent by establishing
38 the division of the premiums between the title insurance company
39 and title insurance agent so that the company receives the premium
40 tax due on the agent's portion of the premiums and remits it to the
41 state. (V.T.I.C. Art. 9.59, Sec. 8(b).)

1 Source Law

2 (b) The premium tax is levied on all amounts
3 defined to be premium in this Chapter, whether paid to
4 the title insurance company or retained by the title
5 insurance agent, such tax being in lieu of the tax on
6 the premium retained by the agent. The State of Texas
7 facilitates the collection of the premium tax on the
8 premium retained by the agent by setting the division
9 of the premium between insurer and agent so that the
10 insurer receives the premium tax due on the agent's
11 portion of the premium and remits it to the State.

12 Revised Law

13 Sec. 223.006. TAX DUE DATES. (a) The total tax imposed by
14 this chapter is due and payable not later than:

15 (1) March 1 after the end of the calendar year for
16 which the tax is due; or

17 (2) another date prescribed by the comptroller.

18 (b) A title insurance company that had a net tax liability
19 for the previous calendar year of more than \$1,000 shall make
20 semiannual prepayments of tax on March 1 and August 1. The tax paid
21 on each date must be equal to 50 percent of the total amount of tax
22 the company paid under this chapter for the previous calendar year.
23 If the company did not pay a tax under this chapter during the
24 previous calendar year, the tax paid on each date must be equal to
25 the tax that would be owed on the aggregate of the gross premiums
26 for the two previous calendar quarters.

27 (c) The comptroller may refund any overpayment of taxes that
28 results from the semiannual prepayment system prescribed by this
29 section. (V.T.I.C. Art. 9.59, Secs. 3(a) (part), (b).)

30 Source Law

31 (a) . . . for each taxable year ending on
32 December 31 of the preceding year . . . and the total
33 amount of the tax due under this article shall be paid
34 on or before March 1 of each year or another date
35 prescribed by the comptroller.

36 (b) A semiannual prepayment of premium tax must
37 be made on March 1 and August 1 by all insurers with net
38 tax liability for the previous calendar year of more
39 than \$1,000. The tax paid on each date must equal
40 one-half of the total premium tax paid for the previous
41 calendar year. If no premium tax has been paid during
42 the previous calendar year, the semiannual payment
43 shall equal the tax that would be owed on the aggregate
44 of the gross premium receipts for the two previous
45 calendar quarters at the minimum tax rate specified by
46 law. The comptroller may refund any overpayment of
47 premium taxes that results from the semiannual

1 minimum standards, and limitations as appropriate to augment and
2 implement this chapter.

3 (b) This section does not affect the comptroller's general
4 authority to adopt rules to promote the efficient administration,
5 collection, enforcement, and reporting of taxes under this code or
6 another insurance law of this state. (V.T.I.C. Art. 9.59, Sec.
7 3(c).)

8 Source Law

9 (c) Without limiting the general authority of
10 the comptroller to adopt rules to promote the
11 efficient administration, collection, enforcement,
12 and reporting of taxes under this code or another
13 insurance law of this state, the commissioner or
14 comptroller, as appropriate, may adopt rules,
15 regulations, minimum standards, and limitations that
16 are fair and reasonable as may be appropriate for the
17 augmentation and implementation of this article.

18 Revisor's Note

19 Section 3(c), V.T.I.C. Article 9.59, refers to
20 "rules" and "regulations." The revised law omits the
21 reference to "regulations" because under Section
22 311.005(5), Government Code (Code Construction Act), a
23 rule is defined to include a regulation. That
24 definition applies to the revised law.

25 Revised Law

26 Sec. 223.009. CREDIT FOR FEES PAID. (a) Except as
27 provided by Section 803.007, a title insurance company is entitled
28 to a credit on the amount of tax due under this chapter for all
29 examination and evaluation fees paid to or for the use of the state
30 during the calendar year for which the tax is due.

31 (b) The credit provided by this section is in addition to
32 any other credit authorized by statute. (V.T.I.C. Art. 9.59, Sec.
33 7.)

34 Source Law

35 Sec. 7. The amount of all examination and
36 evaluation fees paid in each taxable year to or for the
37 use of the State of Texas by a title insurance company
38 shall be allowed as a credit on the amount of premium
39 taxes due under this article except as provided by
40 Article 1.28 of this code. Any credit allowed by this
41 section is in addition to any other credits allowed by

1 law.

2 Revised Law

3 Sec. 223.010. FAILURE TO PAY TAXES. A title insurance
4 company that fails to pay all taxes imposed by this chapter is
5 subject to Section 203.002. (V.T.I.C. Art. 9.59, Sec. 9.)

6 Source Law

7 Sec. 9. A title insurance company failing to pay
8 all taxes imposed by this article is also subject to
9 Article 4.05 of this code.

10 Revisor's Note

11 Section 9, V.T.I.C. Article 9.59, states that a
12 title insurance company that fails to pay taxes is
13 "also" subject to V.T.I.C. Article 4.05, revised in
14 this code in Section 203.002. The revised law omits
15 "also," which relates to the cumulative effect of the
16 section. An accepted principle of statutory
17 construction requires a statute to be given cumulative
18 effect with other statutes unless it provides
19 otherwise or unless the statutes are in conflict. The
20 general principle applies to this revision.

21 Revised Law

22 Sec. 223.011. DISPOSITION OF REVENUE. Chapter 227 applies
23 to the disposition of the revenue from the tax imposed by this
24 chapter. (V.T.I.C. Art. 9.59, Sec. 15.)

25 Source Law

26 Sec. 15. Article 4.12 applies to title
27 insurance companies which are subject to this article.

28 CHAPTER 224. RECIPROCAL AND INTERINSURANCE

29 EXCHANGE PREMIUM TAX

30	Sec. 224.001. APPLICABILITY OF CHAPTER.	70
31	Sec. 224.002. TAX IMPOSED; RATE	71
32	Sec. 224.003. TAXATION ELECTION.	72

33 CHAPTER 224. RECIPROCAL AND INTERINSURANCE EXCHANGE PREMIUM TAX

34 Revised Law

35 Sec. 224.001. APPLICABILITY OF CHAPTER. This chapter
36 applies to a reciprocal or interinsurance exchange that has a

1 certificate of authority to engage in business in this state.
2 (V.T.I.C. Arts. 4.11B, Sec. 1; 4.11C, Sec. 1.)

3 Source Law

4 Art. 4.11B

5 Sec. 1. In this article, "reciprocal exchange"
6 means a reciprocal or interinsurance exchange licensed
7 to transact business in this state.

8 Art. 4.11C

9 Sec. 1. In this article, "reciprocal exchange"
10 has the meaning assigned by Article 4.11B of this code.

11 Revisor's Note

12 Section 1, V.T.I.C. Article 4.11B, refers to a
13 reciprocal or interinsurance exchange "licensed" to
14 transact business in this state. The revised law
15 substitutes "certificate of authority" for license
16 because "certificate of authority" is the term used in
17 Chapter 942 and throughout this code in relation to an
18 exchange's authority to engage in business.

19 Revised Law

20 Sec. 224.002. TAX IMPOSED; RATE. (a) An annual tax is
21 imposed on each reciprocal or interinsurance exchange that:

22 (1) does not file an election to be subject to the tax
23 imposed by Chapter 221 in accordance with Section 224.003; or

24 (2) withdraws that election.

25 (b) The rate of the tax is 1.7 percent of the reciprocal or
26 interinsurance exchange's gross premium receipts.

27 (c) A reciprocal or interinsurance exchange that is subject
28 to the tax imposed by this chapter is not subject to the tax imposed
29 by Chapter 221.

30 (d) Except as provided by Subsection (b), Chapter 221
31 applies to the imposition, computation, and administration of the
32 tax imposed by this chapter in the same manner that Chapter 221
33 applies to the tax imposed by that chapter. (V.T.I.C. Arts. 4.11B,
34 Sec. 2; 4.11C, Secs. 2 (part), 5 (part).)

35 Source Law

36 [Art. 4.11B]

37 Sec. 2. (a) There is imposed on each

1 reciprocal exchange transacting business in this state
2 an annual tax equal to 1.7 percent of its gross premium
3 receipts.

4 (b) Except for the tax rate, the amount of taxes
5 imposed, and the investment provisions, Article 4.10
6 of this code applies to the imposition, computation,
7 and administration of the tax imposed under this
8 article in the same manner that Article 4.10,
9 Insurance Code, applies to the taxes imposed under
10 that article.

11 [Art. 4.11C]

12 Sec. 2. . . . If a reciprocal exchange does not
13 file an election as provided by this article or has
14 withdrawn the election, the reciprocal exchange is
15 subject to the tax imposed under Article 4.11B of this
16 code.

17 Sec. 5. . . . and the gross premiums are not
18 subject to a tax under Article 4.10 of this code if the
19 premiums are taxed under Article 4.11B of this code.

20 Revisor's Note

21 Section 2(b), V.T.I.C. Article 4.11B, states that
22 V.T.I.C. Article 4.10, revised in this code as Chapter
23 221, applies to the computation of taxes "[e]xcept for
24 the tax rate, the amount of taxes imposed, and the
25 investment provisions." The revised law omits the
26 references to the "amount of taxes imposed" and the
27 "investment provisions" because Chapter 852, Acts of
28 the 76th Legislature, Regular Session, 1999, repealed
29 the investment provisions of V.T.I.C. Article 4.10 and
30 the provision in Article 4.10 under which the amount of
31 tax imposed was based on an insurer's investments.

32 Revised Law

33 Sec. 224.003. TAXATION ELECTION. (a) A reciprocal or
34 interinsurance exchange may elect to be subject to the tax imposed
35 by Chapter 221.

36 (b) A reciprocal or interinsurance exchange that elects to
37 be subject to the tax imposed by Chapter 221 must file with the
38 comptroller on a form prescribed by the comptroller a written
39 statement that the exchange has elected to be subject to that tax.
40 The exchange must file the form not later than the 31st day before
41 the date on which the tax year for which the election is to be
42 effective begins.

43 (c) A reciprocal or interinsurance exchange that elects to

1 be subject to the tax imposed by Chapter 221 continues to be subject
2 to that tax for each tax year until the exchange withdraws the
3 election under Subsection (d).

4 (d) A reciprocal or interinsurance exchange may withdraw an
5 election made under Subsection (b) by filing with the comptroller
6 written notice of the withdrawal. The exchange must file the notice
7 not later than the 31st day before the date on which the tax year for
8 which the withdrawal is to be effective begins.

9 (e) A reciprocal or interinsurance exchange that elects to
10 be subject to the tax imposed by Chapter 221 is not subject to the
11 tax imposed by Section 224.002. (V.T.I.C. Art. 4.11C, Secs. 2
12 (part), 3, 5 (part).)

13 Source Law

14 Sec. 2. A reciprocal exchange may elect to be
15 subject to the tax imposed under Article 4.10 of this
16 code, or to be subject to the tax imposed under Article
17 4.11B of this code. A reciprocal exchange that elects
18 to be taxed under Article 4.10 of this code must file
19 with the comptroller not later than the 31st day before
20 the day on which the tax year for which the election is
21 to be effective begins a written statement on a form
22 adopted by the comptroller stating that an election
23 has been made. . . .

24 Sec. 3. A reciprocal exchange that elects to be
25 taxed under Article 4.10 of this code will continue to
26 be taxed under that article for each tax year until
27 written notice is given to the comptroller that the
28 election to be taxed under that article is withdrawn.
29 The notice of withdrawal must be filed with the
30 comptroller not later than the 31st day before the
31 beginning of the tax year for which the withdrawal is
32 to be effective.

33 Sec. 5. The gross premiums of a reciprocal
34 exchange are not subject to a tax under Article 4.11B
35 of this code if the premiums are taxed under Article
36 4.10 of this code,

37 Revisor's Note

38 Section 2, V.T.I.C. Article 4.11C, states that a
39 reciprocal or interinsurance exchange may elect to be
40 taxed under V.T.I.C. Article 4.10, revised in this
41 code as Chapter 221, or under V.T.I.C. Article 4.11B,
42 revised in this chapter. The revised law omits the
43 reference to an election to be taxed under Article
44 4.11B because the only election provided by Article

1 4.11C is the election to be taxed under Article 4.10
2 instead of under Article 4.11B.

3 Revisor's Note
4 (End of Chapter)

5 Section 4, V.T.I.C. Article 4.11C, states that
6 the comptroller may adopt necessary forms and
7 procedures to carry out that article and that the
8 comptroller by rule may change the dates for reporting
9 and paying taxes. The revised law omits the reference
10 to adopting forms and procedures as unnecessary
11 because Section (c), V.T.I.C. Article 1.04D, revised
12 in this code in Section 201.051, authorizes the
13 comptroller to adopt forms and otherwise adopt rules
14 necessary for the comptroller to administer, collect,
15 and enforce insurance taxes. The revised law omits the
16 reference to changing the dates for reporting and
17 paying taxes as unnecessary because Section 2(b),
18 V.T.I.C. Article 4.11B, revised in this chapter as
19 Section 224.002, provides that the tax imposed under
20 this chapter is to be imposed, computed, and
21 administered in the same manner as the tax imposed
22 under V.T.I.C. Article 4.10, revised in this code as
23 Chapter 221. Section 6(c), V.T.I.C. Article 4.10,
24 revised in this code as Section 221.005, provides the
25 comptroller identical authority to change the dates
26 for reporting and paying taxes. The omitted law reads:

27 Sec. 4. The comptroller by rule may
28 adopt necessary forms and procedures to
29 carry out this article. The comptroller by
30 rule may change the dates for reporting and
31 payment of taxes to improve operating
32 efficiencies within the agency, so long as a
33 system of semiannual prepayment of taxes
34 imposed by this article is maintained.

35 CHAPTER 225. SURPLUS LINES INSURANCE PREMIUM TAX

36 Sec. 225.001. DEFINITION. 75

37 Sec. 225.002. APPLICABILITY OF CHAPTER. 75

1 Sec. 225.003. APPLICABILITY OF GENERAL PROVISIONS
2 OF OTHER LAW 76
3 Sec. 225.004. TAX IMPOSED; RATE 76
4 Sec. 225.005. TAX EXCLUSIVE 77
5 Sec. 225.006. COLLECTION OF TAX BY AGENT 77
6 Sec. 225.007. COLLECTED TAXES HELD IN TRUST 78
7 Sec. 225.008. TAX PAYMENT, REPORT, AND DUE DATE 78
8 Sec. 225.009. PREPAYMENT OF TAX 78
9 Sec. 225.010. TAX ABSORPTION AND REBATES PROHIBITED 79
10 Sec. 225.011. CANCELED OR REWRITTEN INSURANCE CONTRACT 79
11 Sec. 225.012. STATE AS PREFERRED CREDITOR 79
12 Sec. 225.013. FAILURE TO PAY TAXES; CRIMINAL PENALTY 80

13 CHAPTER 225. SURPLUS LINES INSURANCE PREMIUM TAX

14 Revised Law

15 Sec. 225.001. DEFINITION. In this chapter, "premium"
16 includes:

- 17 (1) a premium;
- 18 (2) a membership fee;
- 19 (3) an assessment;
- 20 (4) dues; and
- 21 (5) any other consideration for surplus lines

22 insurance. (V.T.I.C. Art. 1.14-2, Sec. 12(a) (part).)

23 Source Law

24 Sec. 12. (a) . . . The term premium includes
25 all premiums, membership fees, assessments, dues or
26 any other consideration for insurance. . . .

27 Revised Law

28 Sec. 225.002. APPLICABILITY OF CHAPTER. This chapter
29 applies to a surplus lines agent who collects gross premiums for
30 surplus lines insurance. (V.T.I.C. Art. 1.14-2, Sec. 12(a)
31 (part).)

32 Source Law

33 (a) The premiums charged for surplus lines
34 insurance are subject to a premium receipts tax [of
35 4.85 percent of] gross [premiums charged for such
36 insurance.] . . . The surplus lines agent [shall
37 collect from the insured the amount of the tax]

1 Revised Law

2 Sec. 225.003. APPLICABILITY OF GENERAL PROVISIONS OF OTHER
3 LAW. The provisions of Chapter 981, including provisions relating
4 to the applicability and enforcement of that chapter, rulemaking
5 authority under that chapter, and definitions of terms applicable
6 in that chapter, apply to this chapter. (V.T.I.C. Art. 1.14-2,
7 Sec. 12(e).)

8 Source Law

9 (e) The provisions of Chapter 981 of this code,
10 including provisions relating to the applicability and
11 enforcement of that chapter, rulemaking authority
12 under that chapter, and definitions of terms
13 applicable in that chapter, apply to this section.

14 Revised Law

15 Sec. 225.004. TAX IMPOSED; RATE. (a) A tax is imposed on
16 gross premiums for surplus lines insurance. The rate of the tax is
17 4.85 percent of the gross premiums.

18 (b) Taxable gross premiums under this section are based on
19 gross premiums written or received for surplus lines insurance
20 placed through an eligible surplus lines insurer during a calendar
21 year.

22 (c) If a surplus lines insurance policy covers risks or
23 exposures only partially located in this state, the tax is computed
24 on the portion of the premium that is properly allocated to a risk
25 or exposure located in this state.

26 (d) In determining the amount of taxable premiums under
27 Subsection (c), a premium, other than a premium properly allocated
28 or apportioned and reported as a premium that may be subject to
29 taxation by another state, is considered to be written on property
30 or risks located or resident in this state if the premium:

31 (1) is written, procured, or received in this state;

32 or

33 (2) is for a policy negotiated in this state.

34 (e) The following premiums are not taxable in this state:

35 (1) premiums properly allocated to another state that
36 are specifically exempt from taxation in that state; and

1 (2) premiums on risks or exposures that are properly
2 allocated to federal or international waters or are under the
3 jurisdiction of a foreign government. (V.T.I.C. Art. 1.14-2, Sec.
4 12(a) (part).)

5 Source Law

6 (a) The premiums charged for surplus lines
7 insurance are subject to a premium receipts tax of 4.85
8 percent of gross premiums charged for such insurance.
9 The term premium includes all premiums, membership
10 fees, assessments, dues or any other consideration for
11 insurance. . . . The amount of taxes shall be based on
12 gross premiums written or received for such insurance
13 placed through an eligible surplus lines insurer
14 during the calendar year ending on the preceding
15 December 31. . . . If a surplus lines policy covers
16 risks or exposures only partially in this state, the
17 tax payable shall be computed on the portions of the
18 premium which are properly allocated to the risks or
19 exposures located in this state. In determining the
20 amount of premiums taxable in this state, all premiums
21 written, procured, or received in this state and all
22 premiums on policies negotiated in this state shall be
23 deemed written on property or risks located or
24 resident in this state, except such premiums as are
25 properly allocated or apportioned and reported as
26 premiums which may be subject to taxation by any other
27 state or states. Premiums that are properly allocated
28 to any other state or states that are specifically
29 exempt from taxation under the regulations of that
30 state or states are not taxable in this state.
31 Premiums on risks or exposures which are properly
32 allocated to federal waters, international waters or
33 under the jurisdiction of a foreign government shall
34 not be taxable by this state. . . .

35 Revised Law

36 Sec. 225.005. TAX EXCLUSIVE. The tax imposed by this
37 chapter is in lieu of all other insurance taxes. (V.T.I.C.
38 Art. 1.14-2, Sec. 12(a) (part).)

39 Source Law

40 (a) . . . Such tax shall be in lieu of all
41 other insurance taxes. . . .

42 Revised Law

43 Sec. 225.006. COLLECTION OF TAX BY AGENT. The surplus
44 lines agent shall collect from the insured the tax imposed by this
45 chapter at the time of delivery of the cover note, certificate of
46 insurance, policy, or other initial confirmation of insurance and
47 the full amount of the gross premium charged by the eligible surplus
48 lines insurer for the insurance. (V.T.I.C. Art. 1.14-2, Sec. 12(a))

1 (part).)

2 Source Law

3 (a) . . . The surplus lines agent shall collect
4 from the insured the amount of the tax at the time of
5 delivery of the cover note, certificate of insurance,
6 policy or other initial confirmation of insurance, in
7 addition to the full amount of the gross premium
8 charged by the insurer for the insurance. . . .

9 Revised Law

10 Sec. 225.007. COLLECTED TAXES HELD IN TRUST. A surplus
11 lines agent holds taxes collected under this chapter in trust.
12 (V.T.I.C. Art. 1.14-2, Sec. 12(b) (part).)

13 Source Law

14 (b) All surplus lines premium receipt taxes
15 collected by a surplus lines agent are trust funds in
16 his hands. . . .

17 Revised Law

18 Sec. 225.008. TAX PAYMENT, REPORT, AND DUE DATE. (a) The
19 tax imposed by this chapter is due and payable on or before March 1.
20 A surplus lines agent shall file a tax report with the tax payment.

21 (b) A surplus lines agent shall pay the tax imposed by this
22 chapter and file the report using forms prescribed by the
23 comptroller. (V.T.I.C. Art. 1.14-2, Sec. 12(a) (part).)

24 Source Law

25 (a) . . . The surplus lines agent shall file a
26 report and pay taxes to the comptroller on or before
27 March 1 of each year on forms prescribed by the
28 comptroller. . . .

29 Revisor's Note

30 Section 12(a), V.T.I.C. Article 1.14-2, requires
31 a surplus lines agent to pay a premium tax "to the
32 comptroller." The revised law omits the reference to
33 the comptroller as unnecessary. Section (a), V.T.I.C.
34 Article 1.04D, revised in this code in Section
35 201.051(a), requires the comptroller to collect taxes
36 imposed under this code.

37 Revised Law

38 Sec. 225.009. PREPAYMENT OF TAX. (a) A surplus lines
39 agent shall prepay the tax imposed by this chapter when the amount

1 of the accrued taxes due is equal to at least \$70,000.

2 (b) A surplus lines agent shall prepay the taxes using a
3 form prescribed by the comptroller. The prepayment is due on or
4 before the 15th day of the month following the month in which the
5 amount of taxes described by this section accrues. (V.T.I.C.
6 Art. 1.14-2, Sec. 12(a) (part).)

7 Source Law

8 (a) . . . A tax prepayment shall be required any
9 time accrued taxes due equal or exceed \$70,000. The
10 prepayment of the accrued taxes, with a form
11 prescribed by the comptroller, shall be due by the 15th
12 day of the month following the month in which accrued
13 taxes total \$70,000. . . .

14 Revised Law

15 Sec. 225.010. TAX ABSORPTION AND REBATES PROHIBITED. (a)
16 A surplus lines agent may not absorb the tax imposed by this
17 chapter.

18 (b) A surplus lines agent may not rebate all or part of the
19 tax or the agent's commission as an inducement for insurance or for
20 any other reason. (V.T.I.C. Art. 1.14-2, Sec. 12(a) (part).)

21 Source Law

22 (a) . . . No agent shall absorb such tax nor
23 shall any agent, as an inducement for insurance or for
24 any other reason, rebate all or any part of such tax or
25 his commission. . . .

26 Revised Law

27 Sec. 225.011. CANCELED OR REWRITTEN INSURANCE CONTRACT. If
28 a surplus lines insurance contract is canceled and rewritten, the
29 additional premium for purposes of the tax imposed by this chapter
30 is the premium amount that exceeds the unearned premium of the
31 canceled contract. (V.T.I.C. Art. 1.14-2, Sec. 12(a) (part).)

32 Source Law

33 (a) . . . In event of cancellation and
34 rewriting of any surplus lines insurance contract the
35 additional premium for premium receipts tax purposes
36 shall be the premium in excess of the unearned premium
37 of the canceled insurance contract.

38 Revised Law

39 Sec. 225.012. STATE AS PREFERRED CREDITOR. If the property
40 of a surplus lines agent is seized as the result of an intermediate

1 or final decision of a court in this state, or if the business of a
2 surplus lines agent is suspended by the action of a creditor or
3 turned over to an assignee, receiver, or trustee, the tax imposed by
4 this chapter and penalties due the state from the agent are
5 preferred claims and the state is a preferred creditor and must be
6 paid in full. (V.T.I.C. Art. 1.14-2, Sec. 12(c).)

7 Source Law

8 (c) If the property of any surplus lines agent
9 is seized upon any mesne or final process in any court
10 in this state, or when the business of any surplus
11 lines agent is suspended by the action of creditors or
12 put into the hands of any assignee, receiver or
13 trustee, all surplus lines premium receipts tax money
14 and penalties due the state from such surplus lines
15 agent shall be considered preferred claims and the
16 state shall be a preferred creditor and shall be paid
17 in full.

18 Revisor's Note

19 Section 12(c), V.T.I.C. Article 1.14-2, refers to
20 property "seized upon any mesne or final process in any
21 court." The revised law substitutes "intermediate"
22 for "mesne" because the terms are synonymous and the
23 former is more consistent with modern usage. The
24 revised law also substitutes "final decision" for
25 "final process" because the phrases are synonymous and
26 the former is more commonly used.

27 Revised Law

28 Sec. 225.013. FAILURE TO PAY TAXES; CRIMINAL PENALTY. (a)
29 A surplus lines agent who does not pay the tax imposed by this
30 chapter on or before the due date required by this chapter or who
31 fraudulently withholds, appropriates, or otherwise uses any
32 portion of the tax commits the offense of theft, regardless of
33 whether the surplus lines agent has or claims an interest in the
34 tax.

35 (b) An offense under this section is punishable as provided
36 by law. (V.T.I.C. Art. 1.14-2, Sec. 12(b) (part).)

37 Source Law

38 (b) . . . Any surplus lines agent who fails or
39 refuses to pay over to the state the surplus lines

1 premium receipts tax at the time required by this
2 section, or who fraudulently withholds or appropriates
3 or otherwise uses such money or any portions thereof
4 belonging to the state is guilty of theft and shall be
5 punished as provided by law for the crime of theft,
6 irrespective of whether any such surplus lines agent
7 has or claims to have any interest in such money so
8 received by him.

9 Revisor's Note
10 (End of Chapter)

11 (1) Section 12(d), V.T.I.C. Article 1.14-2,
12 requires the attorney general to institute court
13 proceedings to recover "license fees not paid [by a
14 surplus lines agent] within the time prescribed" by
15 Chapter 981, Insurance Code. The revised law omits
16 this provision as misleading and unnecessary because a
17 surplus lines agent may not receive a license or other
18 authorization to engage in the business of insurance
19 without paying a fee required under Chapter 981. Thus,
20 the attorney general does not institute court
21 proceedings to "recover license fees." The omitted
22 law reads:

23 (d) The Attorney General, upon
24 request of the commissioner, shall proceed
25 in the courts of this or any other state or
26 in any federal court or agency to recover
27 license fees not paid within the time
28 prescribed in this Article. . . .

29 (2) Section 12(d), V.T.I.C. Article 1.14-2,
30 provides that Subtitles A and B, Title 2, Tax Code, and
31 their subsequent amendments, apply to a tax collected
32 under this article. The revised law omits that
33 language as unnecessary. The reference to Subtitles A
34 and B is omitted because Section 111.0022, Tax Code,
35 states that Subtitles A and B apply to the
36 administration, collection, and enforcement of any tax
37 the comptroller is required or authorized to collect
38 under a law other than the Tax Code. The reference to
39 "subsequent amendments" is omitted because under
40 Section 311.027, Government Code (Code Construction
41 Act), unless expressly provided otherwise, a reference

1 to a statute applies to all reenactments, revisions,
2 or amendments of that statute. The omitted law reads:

3 (d) . . . Notwithstanding the
4 preceding sentence, Subtitles A and B,
5 Title 2, Tax Code, and their subsequent
6 amendments, apply to a tax collected under
7 this Article.

8 CHAPTER 226. UNAUTHORIZED AND INDEPENDENTLY PROCURED
9 INSURANCE PREMIUM TAX

10 SUBCHAPTER A. UNAUTHORIZED INSURANCE PREMIUM TAX

11 Sec. 226.001. DEFINITION. 82
12 Sec. 226.002. APPLICABILITY OF SUBCHAPTER. 83
13 Sec. 226.003. TAX IMPOSED; RATE 83
14 Sec. 226.004. TAX EXCLUSIVE 85
15 Sec. 226.005. TAX PAYMENT; DUE DATE. 85

16 [Sections 226.006-226.050 reserved for expansion]

17 SUBCHAPTER B. INDEPENDENTLY PROCURED INSURANCE PREMIUM TAX

18 Sec. 226.051. DEFINITION. 86
19 Sec. 226.052. APPLICABILITY OF SUBCHAPTER. 86
20 Sec. 226.053. TAX IMPOSED; RATE 86
21 Sec. 226.054. TAX PAYMENT BY CERTAIN INSUREDS 87
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24 CHAPTER 226. UNAUTHORIZED AND INDEPENDENTLY PROCURED INSURANCE
25 PREMIUM TAX

26 SUBCHAPTER A. UNAUTHORIZED INSURANCE PREMIUM TAX

27 Revised Law

28 Sec. 226.001. DEFINITION. In this subchapter, "premium"
29 includes any consideration for insurance, including:

- 30 (1) a premium;
31 (2) a membership fee;
32 (3) an assessment; or
33 (4) dues. (Ins. Code, Sec. 101.251(a).)

34 Source Law

35 Sec. 101.251. PREMIUM RECEIPTS TAX. (a) In
36 this section, "premium" includes any consideration for
37 insurance, including:

- 1 (1) a premium;
- 2 (2) a membership fee;
- 3 (3) an assessment; or
- 4 (4) dues.

5 Revised Law

6 Sec. 226.002. APPLICABILITY OF SUBCHAPTER. This
7 subchapter applies to an unauthorized insurer who charges gross
8 premiums for insurance on a subject resident, located, or to be
9 performed in this state. (Ins. Code, Sec. 101.251(b) (part).)

10 Source Law

11 (b) . . . an unauthorized insurer [shall
12 pay . . . a premium receipts tax of 4.85 percent] of
13 gross premiums charged for insurance on a subject
14 resident, located, or to be performed in this state.

15 Revised Law

16 Sec. 226.003. TAX IMPOSED; RATE. (a) A tax is imposed on
17 each unauthorized insurer that charges gross premiums subject to
18 taxation under this section. The rate of the tax is 4.85 percent of
19 the gross premiums charged by the unauthorized insurer.

20 (b) Except as otherwise provided by this section, in
21 determining an unauthorized insurer's taxable gross premiums, the
22 insurer shall include any premium for insurance on a subject
23 resident, located, or to be performed in this state.

24 (c) If a policy covers risks or exposures only partially
25 located in this state, the tax is computed on the portion of the
26 premium that is properly allocated to a risk or exposure located in
27 this state.

28 (d) In determining the amount of taxable premiums under
29 Subsection (c), a premium, other than a premium properly allocated
30 or apportioned and reported as a taxable premium of another state,
31 is considered to be written on property or risks located or resident
32 in this state if the premium:

- 33 (1) is written, procured, or received in this state;
- 34 or
- 35 (2) is for a policy negotiated in this state.

36 (e) Insurance on a subject resident, located, or to be
37 performed in this state is considered to be insurance procured,

1 continued, or renewed in this state regardless of the location from
2 which:

- 3 (1) the application is made;
- 4 (2) the negotiations are conducted; or
- 5 (3) the premiums are remitted.

6 (f) Premiums on risks or exposures that are properly
7 allocated to federal waters or international waters or are under
8 the jurisdiction of a foreign government are not taxable by this
9 state.

10 (g) The following premiums are not subject to the tax
11 imposed by this subchapter:

12 (1) premiums on insurance procured by a licensed
13 surplus lines agent from an eligible surplus lines insurer as
14 defined by Chapter 981 on which premium tax is paid in accordance
15 with Chapter 225; and

16 (2) premiums on an independently procured contract of
17 insurance on which premium tax is paid in accordance with
18 Subchapter B. (Ins. Code, Secs. 101.251(b) (part), (c), (d), (e),
19 (f), (j).)

20 Source Law

21 (b) Except as provided by Subsection (j), an
22 unauthorized insurer shall pay . . . a premium
23 receipts tax of 4.85 percent of gross premiums charged
24 for insurance on a subject resident, located, or to be
25 performed in this state.

26 (c) If a policy covers risks or exposures only
27 partially in this state, the tax payable is computed on
28 the portion of the premium that is properly allocated
29 to a risk or exposure located in this state.

30 (d) In determining the amount of taxable
31 premiums under Subsection (c), all premiums, other
32 than premiums properly allocated or apportioned and
33 reported as taxable premiums of another state, that
34 are written, procured, or received in this state or
35 that are for a policy negotiated in this state are
36 considered to be written on property or risks located
37 or resident in this state.

38 (e) Insurance on a subject resident, located, or
39 to be performed in this state is considered to be
40 insurance procured, continued, or renewed in this
41 state regardless of the location from which:

- 42 (1) the application is made;
- 43 (2) the negotiations are conducted; or
- 44 (3) the premiums are remitted.

45 (f) Premiums on risks or exposures that are
46 properly allocated to federal waters or international
47 waters or under the jurisdiction of a foreign

1 government are not taxable by this state.

2 (j) This section does not apply to premiums on:
3 (1) insurance procured by a licensed
4 surplus lines agent from an eligible surplus lines
5 insurer as defined by Article 1.14-2 on which premium
6 tax is paid in accordance with Article 1.14-2; or
7 (2) an independently procured contract of
8 insurance on which premium tax is paid in accordance
9 with this chapter.

10 Revised Law

11 Sec. 226.004. TAX EXCLUSIVE. The tax imposed by this
12 subchapter is in lieu of all other insurance taxes. (Ins. Code,
13 Sec. 101.251(h).)

14 Source Law

15 (h) The tax imposed by this section is in lieu of
16 all other insurance taxes.

17 Revised Law

18 Sec. 226.005. TAX PAYMENT; DUE DATE. (a) The tax imposed
19 by this subchapter is due and payable not later than:

20 (1) March 1 after the end of the calendar year in which
21 the insurance was effectuated, continued, or renewed; or

22 (2) another date prescribed by the comptroller.

23 (b) An unauthorized insurer shall pay the tax imposed by
24 this subchapter using a form prescribed by the comptroller.

25 (c) If an unauthorized insurer defaults in payment of the
26 tax imposed by this subchapter, the insured is responsible for
27 paying the tax. (Ins. Code, Secs. 101.251(b) (part), (g), (i).)

28 Source Law

29 (b) . . . an unauthorized insurer shall pay to
30 the comptroller, on a form prescribed by the
31 comptroller, a premium receipts tax

32 (g) The unauthorized insurer shall pay the
33 premium receipts tax required by this section before:

34 (1) March 1 following the calendar year in
35 which the insurance was effectuated, continued, or
36 renewed; or

37 (2) another date specified by the
38 comptroller.

39 (i) On default of an unauthorized insurer in the
40 payment of the tax, the insured shall pay the tax.

41 Revisor's Note

42 Section 101.251(b), Insurance Code, requires an
43 unauthorized insurer to pay a premium receipts tax "to

1 the comptroller." The revised law omits the reference
2 to the comptroller as unnecessary. Section (a),
3 V.T.I.C. Article 1.04D, revised in this code in
4 Section 201.051(a), requires the comptroller to
5 collect taxes imposed under this code.

6 [Sections 226.006-226.050 reserved for expansion]

7 SUBCHAPTER B. INDEPENDENTLY PROCURED INSURANCE PREMIUM TAX

8 Revised Law

9 Sec. 226.051. DEFINITION. In this subchapter, "premium"
10 includes any consideration for insurance, including:

- 11 (1) a premium;
12 (2) a membership fee; or
13 (3) dues. (Ins. Code, Sec. 101.252(a).)

14 Source Law

15 Sec. 101.252. INDEPENDENTLY PROCURED INSURANCE
16 TAX. (a) In this section, "premium" includes any
17 consideration for insurance, including:

- 18 (1) a premium;
19 (2) a membership fee; or
20 (3) dues.

21 Revised Law

22 Sec. 226.052. APPLICABILITY OF SUBCHAPTER. This
23 subchapter applies to an insured who procures an insurance contract
24 in accordance with Section 101.053(b)(4). (Ins. Code, Sec.
25 101.252(b) (part).)

26 Source Law

27 (b) . . . an insured who procures insurance in
28 accordance with Section 101.053(b)(4), . . . [shall
29 . . . pay an independently procured insurance tax of
30 4.85 percent].

31 Revised Law

32 Sec. 226.053. TAX IMPOSED; RATE. (a) A tax is imposed on
33 each insured at the rate of 4.85 percent of the premium paid for the
34 insurance contract procured in accordance with Section
35 101.053(b)(4).

36 (b) If an insurance contract covers risks or exposures only
37 partially located in this state, the tax is computed on the portion
38 of the premium that is properly allocated to a risk or exposure

1 located in this state.

2 (c) Premiums for individual life or individual disability
3 insurance are not included in determining an insured's taxable
4 premiums. (Ins. Code, Secs. 101.252(b) (part), (c), (g).)

5 Source Law

6 (b) Except as provided by Subsection (g), an
7 insured who procures insurance in accordance with
8 Section 101.053(b)(4), . . . shall:

9
10 (2) pay an independently procured
11 insurance tax of 4.85 percent.

12 (c) If a policy covers risks or exposures only
13 partially located in this state, the tax payable is
14 computed on the portion of the premium that is properly
15 allocated to a risk or exposure located in this state.

16 (g) This section does not apply to premiums for
17 individual life or individual disability insurance.

18 Revisor's Note

19 Section 101.252(c), Insurance Code, refers to an
20 insurance "policy." The revised law substitutes
21 "contract" for "policy" for consistency with the
22 terminology used in Chapter 101, Insurance Code.

23 Revised Law

24 Sec. 226.054. TAX PAYMENT BY CERTAIN INSUREDS. (a) Except
25 as provided by Section 226.055, the tax imposed by this subchapter
26 is due and payable not later than:

27 (1) May 15 after the end of the calendar year in which
28 the insurance was procured, continued, or renewed; or

29 (2) another date prescribed by the comptroller.

30 (b) An insured who fails to withhold from the premium the
31 amount of tax imposed by this subchapter is liable for the amount of
32 the tax and shall pay the tax due.

33 (c) The insured shall file a tax report and pay the tax.

34 (d) The insured may designate another person to file the
35 report and pay the tax. (Ins. Code, Secs. 101.252(b) (part), (d),
36 (e).)

37 Source Law

38 (b) . . . an insured . . . or another person
39 designated by the insured, shall:

40 (1) file a report with the comptroller;

1 and
2 (2) pay an independently procured
3 insurance tax

4 (d) An insured who fails to withhold from the
5 premium the amount of tax imposed under this section is
6 liable for the amount of the tax and shall pay the tax
7 to the comptroller within the time described by
8 Subsection (e).

9 (e) Except as provided by Section 101.253, the
10 report and tax are due on or before:

11 (1) May 15 following the calendar year in
12 which the insurance was procured, continued, or
13 renewed; or

14 (2) another date specified by the
15 comptroller.

16 Revised Law

17 Sec. 226.055. TAX PAYMENT BY CERTAIN CORPORATIONS. The
18 amount of tax due and payable under this subchapter by a corporation
19 that files a franchise tax report shall be reported directly to the
20 comptroller and is due:

21 (1) at the time the franchise tax report is due; or

22 (2) on another date prescribed by the comptroller.

23 (Ins. Code, Sec. 101.253.)

24 Source Law

25 Sec. 101.253. FILING REQUIREMENTS FOR
26 CORPORATIONS. The amount of tax due and payable under
27 Section 101.252 with respect to a corporation that
28 files a franchise tax return shall be reported
29 directly to the comptroller and is due:

30 (1) at the time the franchise tax report is
31 due; or

32 (2) on another date specified by the
33 comptroller.

34 Revised Law

35 Sec. 226.056. EFFECT ON OTHER LAW. Sections
36 226.051-226.054 do not abrogate or modify any other provision of
37 this chapter or Chapter 101. (Ins. Code, Sec. 101.252(f).)

38 Source Law

39 (f) This section does not abrogate or modify any
40 other provision of this chapter.

41 CHAPTER 227. DISPOSITION OF PROCEEDS

42 OF CERTAIN PREMIUM TAXES

43 Sec. 227.001. DISPOSITION OF TAX PROCEEDS 89

44 CHAPTER 227. DISPOSITION OF PROCEEDS

45 OF CERTAIN PREMIUM TAXES

1 Revised Law

2 Sec. 227.001. DISPOSITION OF TAX PROCEEDS. (a) The
3 proceeds of the taxes imposed under Chapter 221, 222, 224, or 226
4 shall be deposited to the credit of the general revenue fund.

5 (b) An amount equal to one-fourth of the proceeds deposited
6 under Subsection (a) shall be transferred to the credit of the
7 foundation school fund. (V.T.I.C. Art. 4.12.)

8 Source Law

9 Art. 4.12. Receipts from the taxes imposed by
10 Articles 4.10, 4.11, and 4.11B and Sections 11 and 12
11 of Article 1.14-1 of this code shall be deposited in
12 the general revenue fund. An amount equal to
13 one-fourth (1/4) of this revenue shall be transferred
14 to the foundation school fund, and an amount equal to
15 three-fourths (3/4) of this revenue shall be credited
16 to the general revenue fund.

17 [Chapters 228-250 reserved for expansion]

18 SUBTITLE C. INSURANCE MAINTENANCE TAXES

19 CHAPTER 251. GENERAL PROVISIONS

20	Sec. 251.001. DETERMINING RATE OF ASSESSMENT	89
21	Sec. 251.002. DUTY TO ADVISE COMPTROLLER OF RATE	92
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23	Sec. 251.004. DEPOSIT OF MAINTENANCE TAXES	96

24 CHAPTER 251. GENERAL PROVISIONS

25 Revised Law

26 Sec. 251.001. DETERMINING RATE OF ASSESSMENT. (a) The
27 commissioner shall annually determine the rate of assessment of
28 each maintenance tax imposed under this subtitle.

29 (b) In determining the rate of assessment, the commissioner
30 shall consider the requirement to reimburse the appropriate portion
31 of the general revenue fund under Section 201.052. (V.T.I.C.
32 Art. 1.14-3, Secs. 8(a) (part), (b) (part); Art. 4.17, Secs. (a)
33 (part), (c) (part); Art. 5.12, Secs. (a) (part), (c) (part);
34 Art. 5.24, Secs. (a) (part), (c) (part); Art. 5.49, Secs. (a)
35 (part), (c) (part); Art. 5.68, Secs. (a) (part), (d) (part);
36 Art. 5.91, Secs. (a) (part), (c) (part); Art. 20A.33, Secs. (d)
37 (part), (f) (part); Art. 21.07-6, Secs. 21(a) (part), (c) (part);

1 Art. 23.08A, Secs. (a) (part), (c) (part).)

2 Source Law

3 [Art. 1.14-3]

4 Sec. 8. (a) The commissioner annually shall
5 determine the rate of assessment of a maintenance
6 tax

7 (b) . . . In making an estimate under this
8 subsection, the commissioner shall take into account
9 the requirement that the general revenue fund be
10 reimbursed under Article 4.19 of this code and its
11 subsequent amendments.

12 Art. 4.17. (a) The commissioner shall annually
13 determine the rate of assessment of a maintenance
14 tax

15 (c) . . . In making an estimate under this
16 subsection, the commissioner shall take into account
17 the requirement that the general revenue fund be
18 reimbursed under Article 4.19 of this code.

19 Art. 5.12. (a) The State of Texas by and
20 through the commissioner shall annually determine the
21 rate of assessment of a maintenance tax

22 (c) . . . In making an estimate under this
23 subsection, the commissioner shall take into account
24 the requirement that the general revenue fund be
25 reimbursed under Article 4.19 of this code.

26 Art. 5.24. (a) The State of Texas by and
27 through the commissioner shall annually determine the
28 rate of assessment of a maintenance tax

29 (c) . . . In making an estimate under this
30 subsection, the board shall take into account the
31 requirement that the general revenue fund be
32 reimbursed under Article 4.19 of this code.

33 Art. 5.49. (a) The State of Texas by and
34 through the commissioner shall annually determine the
35 rate of assessment of a maintenance tax

36 (c) . . . In making an estimate under this
37 subsection, the commissioner shall take into account
38 the requirement that the general revenue fund be
39 reimbursed under Article 4.19 of this code.

40 Art. 5.68. (a) The State of Texas by and
41 through the commissioner shall annually determine the
42 rate of assessment of a maintenance tax

43 (d) . . . In making an estimate under this
44 subsection, the commissioner shall take into account
45 the requirement that the general revenue fund be
46 reimbursed under Article 4.19 of this code.

47 Art. 5.91. (a) The State of Texas by and
48 through the commissioner shall annually determine the
49 rate of assessment of a maintenance tax

50 (c) . . . In making an estimate under this
51 subsection, the commissioner shall take into account
52 the requirement that the general revenue fund be
53 reimbursed under Article 4.19 of this code.

1 [Art. 20A.33]

2 (d) The commissioner shall annually determine
3 the rate of assessment of a . . . maintenance
4 tax

5 (f) . . . In making an estimate under this
6 subsection, the commissioner shall take into account
7 the requirement that the general revenue fund be
8 reimbursed under Article 4.19, Insurance Code.

9 [Art. 21.07-6]

10 Sec. 21. (a) The commissioner annually shall
11 determine the rate of assessment of a maintenance
12 tax

13 (c) . . . In making an estimate under this
14 subsection, the commissioner shall take into account
15 the requirement that the general revenue fund be
16 reimbursed under Article 4.19 of this code.

17 Art. 23.08A. (a) The State of Texas by and
18 through the commissioner shall annually determine the
19 rate of assessment of a maintenance tax

20 (c) . . . In making an estimate under this
21 subsection, the commissioner shall take into account
22 the requirement that the general revenue fund be
23 reimbursed under Article 4.19 of this code.

24 Revisor's Note

25 (1) Section 8(b), V.T.I.C. Article 1.14-3,
26 Section (c), V.T.I.C. Article 4.17, Section (c),
27 V.T.I.C. Article 5.12, Section (c), V.T.I.C. Article
28 5.24, Section (c), V.T.I.C. Article 5.49, Section (d),
29 V.T.I.C. Article 5.68, Section (c), V.T.I.C. Article
30 5.91, Section (f), V.T.I.C. Article 20A.33, Section
31 21(c), V.T.I.C. Article 21.07-6, and Section (c),
32 V.T.I.C. Article 23.08A, refer to reimbursement of
33 "the general revenue fund" under V.T.I.C. Article
34 4.19, revised as Section 201.052 of this code. The
35 revised law substitutes a reference to "the
36 appropriate portion of the general revenue fund" for
37 the quoted language for the reason stated in the
38 revisor's note to Section 201.052.

39 (2) Section 8(b), V.T.I.C. Article 1.14-3,
40 refers to Article 4.19 "and its subsequent
41 amendments." The revised law omits the quoted
42 language because under Section 311.027, Government

1 Code (Code Construction Act), applicable to the
2 revised law, unless expressly provided otherwise, a
3 reference to a statute applies to all reenactments,
4 revisions, or amendments of the statute.

5 (3) Section (c), V.T.I.C. Article 5.24, refers
6 to the "board," meaning the State Board of Insurance.
7 Chapter 685, Acts of the 73rd Legislature, Regular
8 Session, 1993, abolished the State Board of Insurance
9 and transferred its functions to the commissioner of
10 insurance and the Texas Department of Insurance, as
11 appropriate. It is clear from Article 5.24 and other
12 maintenance tax laws that it is the duty of the
13 commissioner to annually determine the rate of
14 assessment of each maintenance tax. The revised law
15 therefore substitutes "commissioner" for "board."

16 Revised Law

17 Sec. 251.002. DUTY TO ADVISE COMPTROLLER OF RATE. The
18 commissioner shall advise the comptroller of the applicable rate of
19 assessment of a maintenance tax not later than the 45th day before
20 the due date of the tax report for the period for which that tax is
21 due. (V.T.I.C. Art. 1.14-3, Sec. 8(d) (part); Art. 4.17, Sec. (g)
22 (part); Art. 5.12, Sec. (f) (part); Art. 5.24, Sec. (f) (part);
23 Art. 5.49, Sec. (f) (part); Art. 5.68, Sec. (g) (part); Art. 5.91,
24 Sec. (f) (part); Art. 20A.33, Sec. (i) (part); Art. 21.07-6, Sec.
25 21(e) (part); Art. 23.08A, Sec. (g) (part).)

26 Source Law

27 [Art. 1.14-3]

28 [Sec. 8]

29 (d) The commissioner shall advise the
30 comptroller of the applicable rate of assessment no
31 later than the date 45 days prior to the due date of the
32 tax return for the period for which such taxes are
33 due. . . .

34 [Art. 4.17]

35 (g) The commissioner shall advise the
36 comptroller of the applicable rate of assessment no
37 later than the date 45 days prior to the due date of the
38 tax return for the period for which such taxes are
39 due. . . .

1 [Art. 5.12]

2 (f) The commissioner shall advise the
3 comptroller of the applicable rate of assessment no
4 later than the date 45 days prior to the due date of the
5 tax return for the period for which such taxes are
6 due. . . .

7 [Art. 5.24]

8 (f) The commissioner shall advise the
9 comptroller of the applicable rate of assessment no
10 later than the date 45 days prior to the due date of the
11 tax return for the period for which such taxes are
12 due. . . .

13 [Art. 5.49]

14 (f) The commissioner shall advise the
15 comptroller of the applicable rate of assessment no
16 later than the date 45 days prior to the due date of the
17 tax return for the period for which such taxes are
18 due. . . .

19 [Art. 5.68]

20 (g) The commissioner shall advise the
21 comptroller of the applicable rate of assessment no
22 later than the date 45 days prior to the due date of the
23 tax return for the period for which such taxes are
24 due. . . .

25 [Art. 5.91]

26 (f) The commissioner shall advise the
27 comptroller of the applicable rate of assessment no
28 later than the date 45 days prior to the due date of the
29 tax return for the period for which such taxes are
30 due. . . .

31 [Art. 20A.33]

32 (i) The commissioner shall advise the
33 comptroller of the applicable rate of assessment no
34 later than the date 45 days prior to the due date of the
35 tax return for the period for which such taxes are
36 due. . . .

37 [Art. 21.07-6]

38 [Sec. 21]

39 (e) The commissioner shall advise the
40 comptroller of the applicable rate of assessment no
41 later than the date 45 days prior to the due date of the
42 tax return for the period for which such taxes are
43 due. . . .

44 [Art. 23.08A]

45 (g) The commissioner shall advise the
46 comptroller of the applicable rate of assessment no
47 later than the date 45 days prior to the due date of the
48 tax return for the period for which such taxes are
49 due. . . .

50 Revisor's Note

51 Section 8(d), V.T.I.C. Article 1.14-3, Section
52 (g), V.T.I.C. Article 4.17, Section (f), V.T.I.C.
53 Article 5.12, Section (f), V.T.I.C. Article 5.24,
54 Section (f), V.T.I.C. Article 5.49, Section (g),
55 V.T.I.C. Article 5.68, Section (f), V.T.I.C. Article

1 5.91, Section (i), V.T.I.C. Article 20A.33, Section
2 21(e), V.T.I.C. Article 21.07-6, and Section (g),
3 V.T.I.C. Article 23.08A, refer to the "tax return."
4 The revised law substitutes "tax report" for "tax
5 return" because, in the context of tax law, a "tax
6 return" is synonymous with a "tax report" and the
7 latter is more commonly used.

8 Revised Law

9 Sec. 251.003. EFFECT OF LATE ADVISEMENT OF RATE. (a)
10 Except as provided by Subsection (b), if the commissioner does not
11 advise the comptroller of the applicable rate of assessment of a
12 maintenance tax by the date required by Section 251.002, the rate of
13 assessment is the rate applied in the previous tax period.

14 (b) If the commissioner advises the comptroller of the
15 applicable rate of assessment of a maintenance tax after the tax has
16 been assessed, the comptroller shall:

17 (1) advise each taxpayer in writing of the amount of
18 any additional taxes due; or

19 (2) refund any excess taxes paid. (V.T.I.C.
20 Art. 1.14-3, Sec. 8(d) (part); Art. 4.17, Sec. (g) (part);
21 Art. 5.12, Sec. (f) (part); Art. 5.24, Sec. (f) (part); Art. 5.49,
22 Sec. (f) (part); Art. 5.68, Sec. (g) (part); Art. 5.91, Sec. (f)
23 (part); Art. 20A.33, Sec. (i) (part); Art. 21.07-6, Sec. 21(e)
24 (part); Art. 23.08A, Sec. (g) (part).)

25 Source Law

26 [Art. 1.14-3]
27 [Sec. 8]

28 (d) . . . If the commissioner has not advised
29 the comptroller of the applicable rate by such date,
30 the applicable rate shall be the rate applied in the
31 previous tax period. If the commissioner advises the
32 comptroller of the applicable rate of assessment after
33 taxes have been assessed pursuant to this subsection,
34 the comptroller shall:

35 (1) advise each taxpayer in writing of the
36 amount of any additional taxes due; or

37 (2) refund any excess taxes paid.

38 [Art. 4.17]

39 (g) . . . If the commissioner has not advised
40 the comptroller of the applicable rate by such date,
41 the applicable rate shall be the rate applied in the

1 previous tax period. If the commissioner advises the
2 comptroller of the applicable rate of assessment after
3 taxes have been assessed pursuant to this subsection,
4 the comptroller shall:

5 (1) advise each taxpayer in writing of the
6 amount of any additional taxes due; or

7 (2) refund any excess taxes paid.

8 [Art. 5.12]

9 (f) . . . If the commissioner has not advised
10 the comptroller of the applicable rate by such date,
11 the applicable rate shall be the rate applied in the
12 previous tax period. If the commissioner advises the
13 comptroller of the applicable rate of assessment after
14 taxes have been assessed pursuant to this subsection,
15 the comptroller shall:

16 (1) advise each taxpayer in writing of the
17 amount of any additional taxes due; or

18 (2) refund any excess taxes paid.

19 [Art. 5.24]

20 (f) . . . If the commissioner has not advised
21 the comptroller of the applicable rate by such date,
22 the applicable rate shall be the rate applied in the
23 previous tax period. If the commissioner advises the
24 comptroller of the applicable rate of assessment after
25 taxes have been assessed pursuant to this subsection,
26 the comptroller shall:

27 (1) advise each taxpayer in writing of the
28 amount of any additional taxes due; or

29 (2) refund any excess taxes paid.

30 [Art. 5.49]

31 (f) . . . If the commissioner has not advised
32 the comptroller of the applicable rate by such date,
33 the applicable rate shall be the rate applied in the
34 previous tax period. If the commissioner advises the
35 comptroller of the applicable rate of assessment after
36 taxes have been assessed pursuant to this subsection,
37 the comptroller shall:

38 (1) advise each taxpayer in writing of the
39 amount of any additional taxes due; or

40 (2) refund any excess taxes paid.

41 [Art. 5.68]

42 (g) . . . If the commissioner has not advised
43 the comptroller of the applicable rate by such date,
44 the applicable rate shall be the rate applied in the
45 previous tax period. If the commissioner advises the
46 comptroller of the applicable rate of assessment after
47 taxes have been assessed pursuant to this subsection,
48 the comptroller shall:

49 (1) advise each taxpayer in writing of the
50 amount of any additional taxes due; or

51 (2) refund any excess taxes paid.

52 [Art. 5.91]

53 (f) . . . If the commissioner has not advised
54 the comptroller of the applicable rate by such date,
55 the applicable rate shall be the rate applied in the
56 previous tax period. If the commissioner advises the
57 comptroller of the applicable rate of assessment after
58 taxes have been assessed pursuant to this subsection,
59 the comptroller shall:

60 (1) advise each taxpayer in writing of the
61 amount of any additional taxes due; or

62 (2) refund any excess taxes paid.

1 [Art. 20A.33]

2 (i) . . . If the commissioner has not advised
3 the comptroller of the applicable rate by such date,
4 the applicable rate shall be the rate applied in the
5 previous tax period. If the commissioner advises the
6 comptroller of the applicable rate of assessment after
7 taxes have been assessed pursuant to this subsection,
8 the comptroller shall:

9 (1) advise each taxpayer in writing of the
10 amount of any additional taxes due; or

11 (2) refund any excess taxes paid.

12 [Art. 21.07-6]

13 [Sec. 21]

14 (e) . . . If the commissioner has not advised
15 the comptroller of the applicable rate by such date,
16 the applicable rate shall be the rate applied in the
17 previous tax period. If the commissioner advises the
18 comptroller of the applicable rate of assessment after
19 taxes have been assessed pursuant to this subsection,
20 the comptroller shall:

21 (1) advise each taxpayer in writing of the
22 amount of any additional taxes due; or

23 (2) refund any excess taxes paid.

24 [Art. 23.08A]

25 (g) . . . If the commissioner has not advised
26 the comptroller of the applicable rate by such date,
27 the applicable rate shall be the rate applied in the
28 previous tax period. If the commissioner advises the
29 comptroller of the applicable rate of assessment after
30 taxes have been assessed pursuant to this subsection,
31 the comptroller shall:

32 (1) advise each taxpayer in writing of the
33 amount of any additional taxes due; or

34 (2) refund any excess taxes paid.

35 Revised Law

36 Sec. 251.004. DEPOSIT OF MAINTENANCE TAXES. Maintenance
37 taxes collected under this subtitle shall be deposited in the
38 general revenue fund and reallocated to the Texas Department of
39 Insurance operating account. (V.T.I.C. Art. 1.14-3, Sec. 8(c)
40 (part); Art. 4.17, Sec. (d) (part); Art. 5.12, Sec. (d) (part);
41 Art. 5.24, Sec. (d) (part); Art. 5.49, Sec. (d) (part); Art. 5.68,
42 Sec. (e) (part); Art. 5.91, Sec. (d) (part); Art. 20A.33, Sec. (g)
43 (part); Art. 21.07-6, Sec. 21(d) (part); Art. 23.08A, Sec. (d)
44 (part).)

45 Source Law

46 [Art. 1.14-3]

47 [Sec. 8]

48 (c) The collected taxes shall be deposited in
49 the State Treasury to the credit of the general revenue
50 fund to be reallocated to the Texas Department of
51 Insurance operating fund and

52 [Art. 4.17]

53 (d) The taxes collected shall be deposited in

1 the state treasury to the credit of the general revenue
2 fund to be reallocated to the Texas Department of
3 Insurance operating fund and

4 [Art. 5.12]

5 (d) The taxes collected shall be deposited in
6 the State Treasury to the credit of the general revenue
7 fund to be reallocated to the Texas Department of
8 Insurance operating fund and

9 [Art. 5.24]

10 (d) The taxes collected shall be deposited in
11 the State Treasury to the credit of the general revenue
12 fund to be reallocated to the Texas Department of
13 Insurance operating fund and

14 [Art. 5.49]

15 (d) The taxes collected shall be deposited in
16 the State Treasury to the credit of the general revenue
17 fund to be reallocated to the Texas Department of
18 Insurance operating fund and

19 [Art. 5.68]

20 (e) The taxes collected shall be deposited in
21 the State Treasury to the credit of the general revenue
22 fund to be reallocated to the Texas Department of
23 Insurance operating fund and

24 [Art. 5.91]

25 (d) The taxes collected shall be deposited in
26 the State Treasury to the credit of the general revenue
27 fund to be reallocated to the Texas Department of
28 Insurance operating fund and

29 [Art. 20A.33]

30 (g) The taxes collected shall be deposited in
31 the State Treasury to the credit of the general revenue
32 fund to be reallocated to the Texas Department of
33 Insurance operating fund and

34 [Art. 21.07-6]

35 [Sec. 21]

36 (d) The taxes collected under this section shall
37 be deposited in the state treasury to the credit of the
38 general revenue fund to be reallocated to the Texas
39 Department of Insurance operating fund and

40 [Art. 23.08A]

41 (d) The taxes collected shall be deposited in
42 the State Treasury to the credit of the general revenue
43 fund to be reallocated to the Texas Department of
44 Insurance operating fund and

45 Revisor's Note

46 (1) Section 8(c), V.T.I.C. Article 1.14-3,
47 Section (d), V.T.I.C. Article 4.17, Section (d),
48 V.T.I.C. Article 5.12, Section (d), V.T.I.C. Article
49 5.24, Section (d), V.T.I.C. Article 5.49, Section (e),
50 V.T.I.C. Article 5.68, Section (d), V.T.I.C. Article
51 5.91, Section (g), V.T.I.C. Article 20A.33, Section
52 21(d), V.T.I.C. Article 21.07-6, and Section (d),

1 V.T.I.C. Article 23.08A, state that collected taxes
2 shall be deposited in the state treasury to the credit
3 of the general revenue fund to be reallocated to the
4 Texas Department of Insurance operating fund. Under
5 the authority of Chapter 4, Acts of the 72nd
6 Legislature, 1st Called Session, 1991, that fund was
7 converted to an account in the general revenue fund.
8 The revised law is drafted accordingly.

9 (2) Section 8(c), V.T.I.C. Article 1.14-3,
10 Section (d), V.T.I.C. Article 4.17, Section (d),
11 V.T.I.C. Article 5.12, Section (d), V.T.I.C. Article
12 5.24, Section (d), V.T.I.C. Article 5.49, Section (e),
13 V.T.I.C. Article 5.68, Section (d), V.T.I.C. Article
14 5.91, Section (g), V.T.I.C. Article 20A.33, Section
15 21(d), V.T.I.C. Article 21.07-6, and Section (d),
16 V.T.I.C. Article 23.08A, require money allocated to
17 the Texas Department of Insurance operating account to
18 be spent as authorized by legislative appropriation on
19 warrants issued by the comptroller pursuant to duly
20 certified requisitions of the commissioner of
21 insurance. The revised law omits that part of each
22 provision relating to the expenditure of money as
23 authorized by legislative appropriation as
24 unnecessary because Section 6, Article VIII, Texas
25 Constitution, provides that "[n]o money shall be drawn
26 from the Treasury but in pursuance of specific
27 appropriations made by law." The revised law also
28 omits that part of each provision relating to warrants
29 issued by the comptroller pursuant to certified
30 requisitions of the commissioner because it is
31 substantively duplicative of provisions contained in
32 Chapter 2103, Government Code, which is a
33 comprehensive law covering procedures for withdrawing
34 money from the state treasury. The omitted law reads:

1 [Art. 1.14-3]
2 [Sec. 8]
3 (c) [The collected taxes shall be
4 deposited . . . to the credit of . . . the
5 Texas Department of Insurance operating
6 fund and] shall be spent as authorized by
7 legislative appropriation on warrants
8 issued by the comptroller pursuant to duly
9 certified requisitions of the
10 commissioner. . . .

11 [Art. 4.17]
12 (d) [The taxes collected shall be
13 deposited . . . to the credit of . . . the
14 Texas Department of Insurance operating
15 fund and] shall be spent as authorized by
16 legislative appropriation on warrants
17 issued by the comptroller pursuant to duly
18 certified requisitions of the
19 commissioner. . . .

20 [Art. 5.12]
21 (d) [The taxes collected shall be
22 deposited . . . to the credit of . . . the
23 Texas Department of Insurance operating
24 fund and] shall be spent as authorized by
25 legislative appropriation only on warrants
26 issued by the comptroller pursuant to duly
27 certified requisitions of the
28 commissioner. . . .

29 [Art. 5.24]
30 (d) [The taxes collected shall be
31 deposited . . . to the credit of . . . the
32 Texas Department of Insurance operating
33 fund and] shall be spent as authorized by
34 legislative appropriation on warrants
35 issued by the comptroller pursuant to duly
36 certified requisitions of the
37 commissioner. . . .

38 [Art. 5.49]
39 (d) [The taxes collected shall be
40 deposited . . . to the credit of . . . the
41 Texas Department of Insurance operating
42 fund and] shall be spent as authorized by
43 legislative appropriation on warrants
44 issued by the comptroller pursuant to duly
45 certified requisitions of the
46 commissioner. . . .

47 [Art. 5.68]
48 (e) [The taxes collected shall be
49 deposited . . . to the credit of . . . the
50 Texas Department of Insurance operating
51 fund and] shall be spent as authorized by
52 legislative appropriation on warrants
53 issued by the comptroller pursuant to duly
54 certified requisitions of the
55 commissioner. . . .

56 [Art. 5.91]
57 (d) [The taxes collected shall be
58 deposited . . . to the credit of . . . the
59 Texas Department of Insurance operating
60 fund and] shall be spent as authorized by
61 legislative appropriation on warrants

1 issued by the comptroller pursuant to duly
2 certified requisitions of the
3 commissioner. . . .

4 [Art. 20A.33]

5 (g) [The taxes collected shall be
6 deposited . . . to the credit of . . . the
7 Texas Department of Insurance operating
8 fund and] shall be spent as authorized by
9 legislative appropriation on warrants
10 issued by the comptroller pursuant to duly
11 certified requisitions of the
12 commissioner. . . .

13 [Art. 21.07-6]

14 [Sec. 21]

15 (d) [The taxes collected under this
16 section shall be deposited . . . to the
17 credit of . . . the Texas Department of
18 Insurance operating fund and] shall be
19 spent as authorized by legislative
20 appropriation on warrants issued by the
21 comptroller pursuant to duly certified
22 requisitions of the commissioner. . . .

23 [Art. 23.08A]

24 (d) [The taxes collected shall be
25 deposited . . . to the credit of . . . the
26 Texas Department of Insurance operating
27 fund and] shall be spent as authorized by
28 legislative appropriation on warrants
29 issued by the comptroller pursuant to duly
30 certified requisitions of the
31 commissioner. . . .

32 (3) Section 8(c), V.T.I.C. Article 1.14-3,
33 Section (d), V.T.I.C. Article 4.17, Section (d),
34 V.T.I.C. Article 5.12, Section (d), V.T.I.C. Article
35 5.24, Section (d), V.T.I.C. Article 5.49, Section (e),
36 V.T.I.C. Article 5.68, Section (d), V.T.I.C. Article
37 5.91, Section (g), V.T.I.C. Article 20A.33, Section
38 21(d), V.T.I.C. Article 21.07-6, and Section (d),
39 V.T.I.C. Article 23.08A, authorize the transfer of
40 money in the Texas Department of Insurance operating
41 account to the general revenue fund in accordance with
42 V.T.I.C. Article 4.19. The revised law omits these
43 provisions as unnecessary because Article 4.19,
44 revised as Section 201.052 of this code, provides
45 sufficient authority for the transfer of that money.
46 The omitted law reads:

47 [Art. 1.14-3]

48 [Sec. 8]

49 (c) . . . Amounts reallocated to

1 the Texas Department of Insurance operating
2 fund under this subsection may be
3 transferred to the general revenue fund in
4 accordance with Article 4.19 of this code
5 and its subsequent amendments.

6 [Art. 4.17]

7 (d) . . . Amounts reallocated to
8 the Texas Department of Insurance operating
9 fund under this subsection may be
10 transferred to the general revenue fund in
11 accordance with Article 4.19 of this code.

12 [Art. 5.12]

13 (d) . . . Amounts reallocated to
14 the Texas Department of Insurance operating
15 fund under this subsection may be
16 transferred to the general revenue fund in
17 accordance with Article 4.19 of this code.

18 [Art. 5.24]

19 (d) . . . Amounts reallocated to
20 the Texas Department of Insurance operating
21 fund under this subsection may be
22 transferred to the general revenue fund in
23 accordance with Article 4.19 of this code.

24 [Art. 5.49]

25 (d) . . . Amounts reallocated to
26 the Texas Department of Insurance operating
27 fund under this subsection may be
28 transferred to the general revenue fund in
29 accordance with Article 4.19 of this code.

30 [Art. 5.68]

31 (e) . . . Amounts reallocated to
32 the Texas Department of Insurance operating
33 fund under this subsection may be
34 transferred to the general revenue fund in
35 accordance with Article 4.19 of this code.

36 [Art. 5.91]

37 (d) . . . Amounts reallocated to
38 the Texas Department of Insurance operating
39 fund under this subsection may be
40 transferred to the general revenue fund in
41 accordance with Article 4.19 of this code.

42 [Art. 20A.33]

43 (g) . . . Amounts reallocated to
44 the Texas Department of Insurance operating
45 fund under this subsection may be
46 transferred to the general revenue fund in
47 accordance with Article 4.19, Insurance
48 Code.

49 [Art. 21.07-6]

50 [Sec. 21]

51 (d) . . . Amounts reallocated to
52 the Texas Department of Insurance operating
53 fund under this subsection may be
54 transferred to the general revenue fund in
55 accordance with Article 4.19 of this code.

56 [Art. 23.08A]

57 (d) . . . Amounts reallocated to
58 the Texas Department of Insurance operating
59 fund under this subsection may be

1 transferred to the general revenue fund in
2 accordance with Article 4.19 of this code.

3 Revisor's Note
4 (End of Chapter)

5 Section 8(a), V.T.I.C. Article 1.14-3, Section
6 (a), V.T.I.C. Article 4.17, Section (a), V.T.I.C.
7 Article 5.12, Section (a), V.T.I.C. Article 5.24,
8 Section (a), V.T.I.C. Article 5.49, Section (a),
9 V.T.I.C. Article 5.68, Section (a), V.T.I.C. Article
10 5.91, Section (d), V.T.I.C. Article 20A.33, Section
11 21(a), V.T.I.C. Article 21.07-6, and Section (a),
12 V.T.I.C. Article 23.08A, state that the comptroller
13 shall collect the maintenance tax. The revised law
14 omits these provisions as unnecessary because V.T.I.C.
15 Article 1.04D, revised in relevant part as Section
16 201.051(a) of this code, provides that the comptroller
17 shall collect the taxes. The omitted law reads:

18 [Art. 1.14-3]
19 Sec. 8. (a) . . . The comptroller
20 shall collect the maintenance tax.

21 Art. 4.17. (a) . . . The
22 comptroller shall collect the maintenance
23 tax. . . .

24 Art. 5.12. (a) . . . The
25 comptroller shall collect the maintenance
26 tax.

27 Art. 5.24. (a) . . . The
28 comptroller shall collect the maintenance
29 tax.

30 Art. 5.49. (a) . . . The
31 comptroller shall collect the maintenance
32 tax.

33 Art. 5.68. (a) . . . The
34 comptroller shall collect the maintenance
35 tax

36 Art. 5.91. (a) . . . The
37 comptroller shall collect the maintenance
38 tax.

39 [Art. 20A.33]
40 (d) . . . The comptroller shall
41 collect the maintenance tax. . . .

42 [Art. 21.07-6]
43 Sec. 21. (a) . . . The comptroller
44 shall collect the maintenance tax.

1 Art. 23.08A. (a) . . . The
2 comptroller shall collect the maintenance
3 tax.

4 CHAPTER 252. FIRE AND ALLIED LINES INSURANCE

5 Sec. 252.001. MAINTENANCE TAX IMPOSED 103
6 Sec. 252.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. 103
7 Sec. 252.003. PREMIUMS SUBJECT TO TAXATION 104
8 Sec. 252.004. MAINTENANCE TAX DUE DATES 105

9 CHAPTER 252. FIRE AND ALLIED LINES INSURANCE

10 Revised Law

11 Sec. 252.001. MAINTENANCE TAX IMPOSED. A maintenance tax
12 is imposed on each authorized insurer with gross premiums subject
13 to taxation under Section 252.003. The tax required by this chapter
14 is in addition to other taxes imposed that are not in conflict with
15 this chapter. (V.T.I.C. Art. 5.49, Secs. (a) (part), (b).)

16 Source Law

17 (a) . . . [a maintenance tax] to be paid
18 on . . . gross premiums . . . [collected] by all
19 authorized insurers [writing those types of
20 insurance]
21 (b) The tax required by this article is in
22 addition to all other taxes now imposed or that may be
23 subsequently imposed and that are not in conflict with
24 this article.

25 Revised Law

26 Sec. 252.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The
27 rate of assessment set by the commissioner may not exceed 1.25
28 percent of the gross premiums subject to taxation under Section
29 252.003.

30 (b) The commissioner shall annually adjust the rate of
31 assessment of the maintenance tax so that the tax imposed that year,
32 together with any unexpended funds produced by the tax, produces
33 the amount the commissioner determines is necessary to pay the
34 expenses during the succeeding year of regulating all classes of
35 insurance specified under Subchapter C, Chapter 5. (V.T.I.C.
36 Art. 5.49, Secs. (a) (part), (c) (part).)

37 Source Law

38 (a) . . . The rate of assessment may not exceed
39 one and one-fourth percent of the . . . [gross
40 premiums]

1 (c) The commissioner, after taking into account
2 the unexpended funds produced by this tax, if any,
3 shall adjust the rate of assessment each year to
4 produce the amount of funds that it estimates will be
5 necessary to pay all the expenses of regulating all
6 classes of insurance specified by this subchapter
7 during the succeeding year. . . .

8 Revised Law

9 Sec. 252.003. PREMIUMS SUBJECT TO TAXATION. An insurer
10 shall pay maintenance taxes under this chapter on the correctly
11 reported gross premiums collected from writing insurance in this
12 state against loss or damage by:

- 13 (1) bombardment;
- 14 (2) civil war or commotion;
- 15 (3) cyclone;
- 16 (4) earthquake;
- 17 (5) excess or deficiency of moisture;
- 18 (6) explosion as defined by Article 5.52;
- 19 (7) fire;
- 20 (8) flood;
- 21 (9) frost and freeze;
- 22 (10) hail;
- 23 (11) insurrection;
- 24 (12) invasion;
- 25 (13) lightning;
- 26 (14) military or usurped power;
- 27 (15) an order of a civil authority made to prevent the
28 spread of a conflagration, epidemic, or catastrophe;
- 29 (16) rain;
- 30 (17) riot;
- 31 (18) the rising of the waters of the ocean or its
32 tributaries;
- 33 (19) smoke or smudge;
- 34 (20) strike or lockout;
- 35 (21) tornado;
- 36 (22) vandalism or malicious mischief;
- 37 (23) volcanic eruption;

1 (24) water or other fluid or substance resulting from
2 the breakage or leakage of sprinklers, pumps, or other apparatus
3 erected for extinguishing fires, water pipes, or other conduits or
4 containers;

5 (25) weather or climatic conditions; or

6 (26) windstorm. (V.T.I.C. Art. 5.49, Sec. (a)
7 (part).)

8 Source Law

9 (a) . . . [a maintenance tax to be paid on . . .
10 the] correctly reported [gross premiums] of fire,
11 lightning, tornado, windstorm, hail, smoke or smudge,
12 cyclone, earthquake, volcanic eruption, rain, frost
13 and freeze, weather or climatic conditions, excess or
14 deficiency of moisture, flood, the rising of the
15 waters of the ocean or its tributaries, bombardment,
16 invasion, insurrection, riot, civil war or commotion,
17 military or usurped power, any order of a civil
18 authority made to prevent the spread of a
19 conflagration, epidemic, or catastrophe, vandalism or
20 malicious mischief, strike or lockout, explosion as
21 defined in Article 5.52 of this code, water or other
22 fluid or substance resulting from the breakage or
23 leakage of sprinklers, pumps, or other apparatus
24 erected for extinguishing fires, water pipes, or other
25 conduits or containers insurance coverage collected
26 [by all authorized insurers] writing those types of
27 insurance in this state. . . .

28 Revised Law

29 Sec. 252.004. MAINTENANCE TAX DUE DATES. (a) The insurer
30 shall pay the maintenance tax annually or semiannually, as
31 determined by the comptroller.

32 (b) The comptroller may require semiannual or other
33 periodic payment only from an insurer whose maintenance tax
34 liability under this chapter for the previous tax year was at least
35 \$2,000. (V.T.I.C. Art. 5.49, Secs. (a) (part), (e).)

36 Source Law

37 (a) . . . [tax to be paid on] an annual or
38 semiannual basis, as determined by the
39 comptroller. . . .

40 (e) The comptroller may elect to collect on a
41 semiannual or other periodic basis the tax assessed
42 under this article only from insurers whose tax
43 liability under this article for the previous tax year
44 was \$2,000 or more.

45 CHAPTER 253. CASUALTY INSURANCE AND FIDELITY, GUARANTY,
46 AND SURETY BOND INSURANCE

1 Sec. 253.001. MAINTENANCE TAX IMPOSED 106
2 Sec. 253.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. 106
3 Sec. 253.003. PREMIUMS SUBJECT TO TAXATION 107
4 Sec. 253.004. MAINTENANCE TAX DUE DATES 107

5 CHAPTER 253. CASUALTY INSURANCE AND FIDELITY, GUARANTY,
6 AND SURETY BOND INSURANCE

7 Revised Law

8 Sec. 253.001. MAINTENANCE TAX IMPOSED. A maintenance tax
9 is imposed on each authorized insurer with gross premiums subject
10 to taxation under Section 253.003. The tax required by this chapter
11 is in addition to other taxes imposed that are not in conflict with
12 this chapter. (V.T.I.C. Art. 5.24, Secs. (a) (part), (b).)

13 Source Law

14 (a) . . . [a maintenance tax] to be paid
15 on . . . gross premiums . . . of all authorized
16 insurers [writing those classes of insurance]
17 (b) The tax required by this article is in
18 addition to all other taxes now imposed or that may be
19 subsequently imposed and that are not in conflict with
20 this article.

21 Revised Law

22 Sec. 253.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The
23 rate of assessment set by the commissioner may not exceed 0.4
24 percent of the gross premiums subject to taxation under Section
25 253.003.

26 (b) The commissioner shall annually adjust the rate of
27 assessment of the maintenance tax so that the tax imposed that year,
28 together with any unexpended funds produced by the tax, produces
29 the amount the commissioner determines is necessary to pay the
30 expenses during the succeeding year of regulating all classes of
31 insurance specified under Subchapter B, Chapter 5. (V.T.I.C.
32 Art. 5.24, Secs. (a) (part), (c) (part).)

33 Source Law

34 (a) . . . The rate of assessment may not exceed
35 two-fifths of one percent of the . . . [gross
36 premiums]

37 (c) The commissioner, after taking into account
38 the unexpended funds produced by this tax, if any,
39 shall adjust the rate of assessment each year to

1 produce the amount of funds that it estimates will be
2 necessary to pay all the expenses of regulating all
3 classes of insurance covered by this subchapter during
4 the succeeding year. . . .

5 Revised Law

6 Sec. 253.003. PREMIUMS SUBJECT TO TAXATION. An insurer
7 shall pay maintenance taxes under this chapter on the correctly
8 reported gross premiums from writing a class of insurance specified
9 under Subchapter B, Chapter 5. (V.T.I.C. Art. 5.24, Sec. (a)
10 (part).)

11 Source Law

12 (a) . . . [a maintenance tax to be paid
13 on . . . the] correctly reported [gross premiums] of
14 all classes of insurance covered by this subchapter
15 [of all authorized insurers] writing those classes of
16 insurance in this state. . . .

17 Revised Law

18 Sec. 253.004. MAINTENANCE TAX DUE DATES. (a) The insurer
19 shall pay the maintenance tax annually or semiannually, as
20 determined by the comptroller.

21 (b) The comptroller may require semiannual payment only
22 from an insurer whose maintenance tax liability under this chapter
23 for the previous tax year was at least \$2,000. (V.T.I.C. Art. 5.24,
24 Secs. (a) (part), (e).)

25 Source Law

26 (a) . . . [tax to be paid on] an annual or
27 semiannual basis, as determined by the
28 comptroller. . . .

29 (e) The comptroller may elect to collect on a
30 semiannual basis the tax assessed under this article
31 only from insurers whose tax liability under this
32 article for the previous tax year was \$2,000 or more.

33 CHAPTER 254. MOTOR VEHICLE INSURANCE

34 Sec. 254.001. MAINTENANCE TAX IMPOSED 107
35 Sec. 254.002. MAXIMUM RATE; ANNUAL ADJUSTMENT 108
36 Sec. 254.003. PREMIUMS SUBJECT TO TAXATION 108
37 Sec. 254.004. MAINTENANCE TAX DUE DATES 109

38 CHAPTER 254. MOTOR VEHICLE INSURANCE

39 Revised Law

40 Sec. 254.001. MAINTENANCE TAX IMPOSED. A maintenance tax

1 is imposed on each authorized insurer with gross premiums subject
2 to taxation under Section 254.003. The tax required by this chapter
3 is in addition to other taxes imposed that are not in conflict with
4 this chapter. (V.T.I.C. Art. 5.12, Secs. (a) (part), (b).)

5 Source Law

6 (a) . . . [a maintenance tax] to be paid on
7 . . . gross . . . premiums of all authorized insurers
8 [writing motor vehicle insurance]

9 (b) The tax required by this article is in
10 addition to all other taxes now imposed or that may be
11 subsequently imposed and that are not in conflict with
12 this article.

13 Revised Law

14 Sec. 254.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The
15 rate of assessment set by the commissioner may not exceed 0.2
16 percent of the gross premiums subject to taxation under Section
17 254.003.

18 (b) The commissioner shall annually adjust the rate of
19 assessment of the maintenance tax so that the tax imposed that year,
20 together with any unexpended funds produced by the tax, produces
21 the amount the commissioner determines is necessary to pay the
22 expenses during the succeeding year of regulating motor vehicle
23 insurance. (V.T.I.C. Art. 5.12, Secs. (a) (part), (c) (part).)

24 Source Law

25 (a) . . . The rate of assessment may not exceed
26 one-fifth of one percent of the . . . [gross . . .
27 premiums]

28 (c) The commissioner, after taking into account
29 the unexpended funds produced by this tax, if any,
30 shall adjust the rate of assessment each year to
31 produce the amount of funds that it estimates will be
32 necessary to pay all the expenses of regulating motor
33 vehicle insurance during the succeeding year. . . .

34 Revised Law

35 Sec. 254.003. PREMIUMS SUBJECT TO TAXATION. An insurer
36 shall pay maintenance taxes under this chapter on the correctly
37 reported gross premiums from writing motor vehicle insurance in
38 this state. (V.T.I.C. Art. 5.12, Sec. (a) (part).)

39 Source Law

40 (a) . . . [a maintenance tax to be paid on . . .
41 the] correctly reported [gross] motor vehicle

1 insurance [premiums of all authorized insurers]
2 writing motor vehicle insurance in this state. . . .

3 Revised Law

4 Sec. 254.004. MAINTENANCE TAX DUE DATES. (a) The insurer
5 shall pay the maintenance tax annually or semiannually, as
6 determined by the comptroller.

7 (b) The comptroller may require semiannual or other
8 periodic payment only from an insurer whose maintenance tax
9 liability under this chapter for the previous tax year was at least
10 \$2,000. (V.T.I.C. Art. 5.12, Secs. (a) (part), (e).)

11 Source Law

12 (a) . . . [tax to be paid on] an annual or
13 semiannual basis, as determined by the comptroller.
14 . . .

15 (e) The comptroller may elect to collect on a
16 semiannual or other periodic basis the tax assessed
17 under this article only from insurers whose tax
18 liability under this article for the previous tax year
19 was \$2,000 or more.

20 CHAPTER 255. WORKERS' COMPENSATION INSURANCE

21	Sec. 255.001. MAINTENANCE TAX IMPOSED	109
22	Sec. 255.002. MAXIMUM RATE; ANNUAL ADJUSTMENT.	110
23	Sec. 255.003. PREMIUMS SUBJECT TO TAXATION	110
24	Sec. 255.004. MAINTENANCE TAX DUE DATES	111

25 CHAPTER 255. WORKERS' COMPENSATION INSURANCE

26 Revised Law

27 Sec. 255.001. MAINTENANCE TAX IMPOSED. (a) A maintenance
28 tax is imposed on each authorized insurer with gross premiums
29 subject to taxation under Section 255.003, including a:

- 30 (1) stock insurance company;
- 31 (2) mutual insurance company;
- 32 (3) reciprocal or interinsurance exchange; and
- 33 (4) Lloyd's plan.

34 (b) The tax required by this chapter is in addition to other
35 taxes imposed that are not in conflict with this chapter. (V.T.I.C.
36 Art. 5.68, Secs. (a) (part), (c).)

37 Source Law

38 (a) . . . [a maintenance tax] . . . from each

1 stock company, mutual company, reciprocal or
2 interinsurance exchange, and Lloyd's
3 association. . . . gross . . . premiums of all
4 authorized insurers [writing workers' compensation
5 insurance]

6 (c) The tax required by this article is in
7 addition to all other taxes now imposed or that may be
8 subsequently imposed and that are not in conflict with
9 this article.

10 Revised Law

11 Sec. 255.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The
12 rate of assessment set by the commissioner may not exceed 0.6
13 percent of the gross premiums subject to taxation under Section
14 255.003.

15 (b) The commissioner shall annually adjust the rate of
16 assessment of the maintenance tax so that the tax imposed that year,
17 together with any unexpended funds produced by the tax, produces
18 the amount the commissioner determines is necessary to pay the
19 expenses during the succeeding year of regulating workers'
20 compensation insurance. (V.T.I.C. Art. 5.68, Secs. (a) (part), (d)
21 (part).)

22 Source Law

23 (a) . . . The rate of assessment may not exceed
24 three-fifths of one percent of the . . . [gross . . .
25 premiums]

26 (d) The commissioner, after taking into account
27 the unexpended funds produced by this tax, if any,
28 shall adjust the rate of assessment each year to
29 produce the amount of funds that it estimates will be
30 necessary to pay all the expenses of regulating
31 workers' compensation insurance during the succeeding
32 year. . . .

33 Revised Law

34 Sec. 255.003. PREMIUMS SUBJECT TO TAXATION. (a) An
35 insurer shall pay maintenance taxes under this chapter on the
36 correctly reported gross workers' compensation insurance premiums
37 from writing workers' compensation insurance in this state,
38 including the modified annual premium of a policyholder that
39 purchases an optional deductible plan under Article 5.55C.

40 (b) The rate of assessment shall be applied to the modified
41 annual premium before application of a deductible premium credit.
42 (V.T.I.C. Art. 5.68, Secs. (a) (part), (b) (part).)

1 Source Law

2 (a) . . . [a maintenance tax] on . . . [the]
3 correctly reported [gross] workers' compensation
4 insurance [premiums of all authorized insurers]
5 writing workers' compensation insurance in this state.

6 (b) For purposes of this article and . . . ,
7 gross workers' compensation insurance premiums include
8 the modified annual premium of a policyholder that
9 purchases a deductible pursuant to Article 5.55C of
10 this code, and the rate of assessment shall be applied
11 to the modified annual premium prior to application of
12 any deductible premium credit.

13 Revised Law

14 Sec. 255.004. MAINTENANCE TAX DUE DATES. (a) The insurer
15 shall pay the maintenance tax annually or semiannually.

16 (b) The comptroller may require semiannual payment only
17 from an insurer whose maintenance tax liability under this chapter
18 for the previous tax year was at least \$2,000. (V.T.I.C. Art. 5.68,
19 Secs. (a) (part), (f).)

20 Source Law

21 (a) . . . [tax on] an annual or semiannual
22 basis. . . .

23 (f) The comptroller may elect to collect on a
24 semiannual basis the tax assessed under this article
25 only from insurers whose tax liability under this
26 article for the previous tax year was \$2,000 or more.

27 CHAPTER 256. AIRCRAFT INSURANCE

28	Sec. 256.001. MAINTENANCE TAX IMPOSED	111
29	Sec. 256.002. MAXIMUM RATE; ANNUAL ADJUSTMENT.	112
30	Sec. 256.003. PREMIUMS SUBJECT TO TAXATION	112
31	Sec. 256.004. MAINTENANCE TAX DUE DATES	112

32 CHAPTER 256. AIRCRAFT INSURANCE

33 Revised Law

34 Sec. 256.001. MAINTENANCE TAX IMPOSED. A maintenance tax
35 is imposed on each authorized insurer with gross premiums subject
36 to taxation under Section 256.003. The tax required by this chapter
37 is in addition to other taxes imposed that are not in conflict with
38 this chapter. (V.T.I.C. Art. 5.91, Secs. (a) (part), (b).)

39 Source Law

40 (a) . . . [a maintenance tax] to be paid on
41 . . . gross premiums . . . of all authorized insurers
42 [writing those classes of insurance]

1 (b) The tax required by this article is in
2 addition to all other taxes now imposed or that may be
3 subsequently imposed and that are not in conflict with
4 this article.

5 Revised Law

6 Sec. 256.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The
7 rate of assessment set by the commissioner may not exceed 0.4
8 percent of the gross premiums subject to taxation under Section
9 256.003.

10 (b) The commissioner shall annually adjust the rate of
11 assessment of the maintenance tax so that the tax imposed that year,
12 together with any unexpended funds produced by the tax, produces
13 the amount the commissioner determines is necessary to pay the
14 expenses during the succeeding year of regulating all classes of
15 insurance specified under Subchapter K, Chapter 5. (V.T.I.C.
16 Art. 5.91, Secs. (a) (part), (c) (part).)

17 Source Law

18 (a) . . . The rate of assessment may not exceed
19 two-fifths of one percent of the . . . [gross
20 premiums]

21 (c) The commissioner, after taking into account
22 the unexpended funds produced by this tax, if any,
23 shall adjust the rate of assessment each year to
24 produce the amount of funds that it estimates will be
25 necessary to pay all the expenses of regulating all
26 classes of insurance specified by this subchapter
27 during the succeeding year. . . .

28 Revised Law

29 Sec. 256.003. PREMIUMS SUBJECT TO TAXATION. An insurer
30 shall pay maintenance taxes under this chapter on the correctly
31 reported gross premiums from writing a class of insurance specified
32 under Subchapter K, Chapter 5. (V.T.I.C. Art. 5.91, Sec. (a)
33 (part).)

34 Source Law

35 (a) . . . [a maintenance tax to be paid on . . .
36 the] correctly reported [gross premiums] on all
37 classes of insurance covered by this subchapter [of
38 all authorized insurers] writing those classes of
39 insurance in this state. . . .

40 Revised Law

41 Sec. 256.004. MAINTENANCE TAX DUE DATES. (a) The insurer
42 shall pay the maintenance tax annually or semiannually, as

1 determined by the comptroller.

2 (b) The comptroller may require semiannual payment only
3 from an insurer whose maintenance tax liability under this chapter
4 for the previous tax year was at least \$2,000. (V.T.I.C. Art. 5.91,
5 Secs. (a) (part), (e).)

6 Source Law

7 (a) . . . [tax to be paid on] an annual or
8 semiannual basis, as determined by the
9 comptroller. . . .

10 (e) The comptroller may elect to collect on a
11 semiannual basis the tax assessed under this article
12 only from insurers whose tax liability under this
13 article for the previous tax year was \$2,000 or more.

14 CHAPTER 257. LIFE, HEALTH, AND ACCIDENT INSURANCE

15	Sec. 257.001.	MAINTENANCE TAX IMPOSED	113
16	Sec. 257.002.	MAXIMUM RATE; ANNUAL ADJUSTMENT.	114
17	Sec. 257.003.	PREMIUMS AND CONSIDERATIONS SUBJECT TO	
18		TAXATION; LIMIT.	115
19	Sec. 257.004.	MAINTENANCE TAX DUE DATES	115

20 CHAPTER 257. LIFE, HEALTH, AND ACCIDENT INSURANCE

21 Revised Law

22 Sec. 257.001. MAINTENANCE TAX IMPOSED. A maintenance tax
23 is imposed on each authorized insurer, including a group hospital
24 service corporation, local mutual aid association, statewide
25 mutual assessment company, stipulated premium company, and stock or
26 mutual insurance company, that collects from residents of this
27 state gross premiums or gross considerations subject to taxation
28 under Section 257.003. The tax required by this chapter is in
29 addition to other taxes imposed that are not in conflict with this
30 chapter. (V.T.I.C. Art. 4.17, Secs. (a) (part), (b), (f).)

31 Source Law

32 (a) . . . [a maintenance tax] to be paid on
33 . . . gross premiums . . . and the gross
34 considerations . . . [collected] by all authorized
35 insurers [writing life, health, and accident
36 insurance, annuity, or endowment contracts]

37 (b) The tax required by this article is in
38 addition to all other taxes now imposed or that may be
39 subsequently imposed and that are not in conflict with
40 this article.

1 (f) The insurers subject to the tax imposed by
2 this article include stock and mutual insurance
3 companies, local mutual aid associations, statewide
4 mutual assessment companies, group hospital service
5 plan corporations, and stipulated premium insurance
6 companies collecting those gross premiums and
7 considerations from residents of this state.

8 Revisor's Note

9 Section (f), V.T.I.C. Article 4.17, refers to
10 "group hospital service plan corporations," meaning
11 corporations operating under V.T.I.C. Chapter 20,
12 revised as Chapter 842 of this code. The term most
13 frequently used to refer to such a corporation is
14 "group hospital service corporation." Consequently,
15 the revised law substitutes "group hospital service
16 corporation" for "group hospital service plan
17 corporations" to provide for consistent use of
18 terminology in this code.

19 Revised Law

20 Sec. 257.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The
21 rate of assessment set by the commissioner may not exceed 0.04
22 percent of the gross premiums and gross considerations subject to
23 taxation under Section 257.003.

24 (b) The commissioner shall annually adjust the rate of
25 assessment of the maintenance tax so that the tax imposed that year,
26 together with any unexpended funds produced by the tax, produces
27 the amount the commissioner determines is necessary to pay the
28 expenses during the succeeding year of regulating life, health, and
29 accident insurers. (V.T.I.C. Art. 4.17, Secs. (a) (part), (c)
30 (part).)

31 Source Law

32 (a) . . . The rate of assessment may not exceed
33 .04 percent of the . . . [gross premiums . . . and the
34 gross considerations]

35 (c) The commissioner, after taking into account
36 the unexpended funds produced by this tax, if any,
37 shall adjust the rate of assessment each year to
38 produce the amount of funds that it estimates will be
39 necessary to pay all the expenses of regulating life,
40 health, and accident insurers during the succeeding
41 year. . . .

1 Revised Law

2 Sec. 257.003. PREMIUMS AND CONSIDERATIONS SUBJECT TO
3 TAXATION; LIMIT. (a) An insurer shall pay maintenance taxes
4 under this chapter on the correctly reported:

5 (1) gross premiums collected from writing life,
6 health, and accident insurance in this state, except as provided in
7 Subsection (b); and

8 (2) gross considerations collected from writing
9 annuity or endowment contracts in this state.

10 (b) The gross premiums on which an assessment is based under
11 this chapter may not include premiums received from this state or
12 the United States for insurance contracted for by this state or the
13 United States:

14 (1) in accordance with or in furtherance of Title 2,
15 Human Resources Code, or the Social Security Act (42 U.S.C. Section
16 301 et seq.); or

17 (2) to provide welfare benefits to designated welfare
18 recipients. (V.T.I.C. Art. 4.17, Sec. (a) (part).)

19 Source Law

20 (a) . . . [a maintenance tax to be paid on . . .
21 the] correctly reported [gross premiums] of life,
22 health, and accident insurance coverages [and the
23 gross considerations] for annuity and endowment
24 contracts collected [by all authorized insurers]
25 writing life, health, and accident insurance, annuity,
26 or endowment contracts in this state. . . . For
27 purposes of this article, the gross premiums on which
28 an assessment is based may not include premiums
29 received from this state or the United States for
30 insurance contracted for by this state or the United
31 States for the purpose of providing welfare benefits
32 to designated welfare recipients or for insurance
33 contracted for by this state or the United States in
34 accordance with or in furtherance of Title 2, Human
35 Resources Code, or the federal Social Security Act (42
36 U.S.C. Section 301 et seq.).

37 Revised Law

38 Sec. 257.004. MAINTENANCE TAX DUE DATES. (a) The insurer
39 shall pay the maintenance tax annually, semiannually, or on another
40 periodic basis, as determined by the comptroller.

41 (b) The comptroller may require semiannual or other
42 periodic payment only from an insurer whose maintenance tax

1 liability under this chapter for the previous year was at least
2 \$2,000. (V.T.I.C. Art. 4.17, Secs. (a) (part), (e).)

3 Source Law

4 (a) . . . [tax to be paid on] an annual,
5 semiannual, or other periodic basis, as determined by
6 the comptroller. . . .

7 (e) The comptroller may collect the tax assessed
8 under this article on a semiannual or other periodic
9 basis from those insurers whose tax liability under
10 this article for the previous year was \$2,000 or more.

11 CHAPTER 258. HEALTH MAINTENANCE ORGANIZATIONS

12 Sec. 258.001. APPLICABILITY OF CERTAIN DEFINITIONS. 116
13 Sec. 258.002. MAINTENANCE TAX IMPOSED 116
14 Sec. 258.003. MAXIMUM RATE; ANNUAL ADJUSTMENT. 117
15 Sec. 258.004. REVENUES SUBJECT TO TAXATION; LIMIT 117
16 Sec. 258.005. MAINTENANCE TAX DUE DATES 118

17 CHAPTER 258. HEALTH MAINTENANCE ORGANIZATIONS

18 Revised Law

19 Sec. 258.001. APPLICABILITY OF CERTAIN DEFINITIONS. In
20 this chapter, a term defined by Section 843.002 has the meaning
21 assigned by that section. (V.T.I.C. Art. 20A.01B, as added Acts
22 77th Leg., R.S., Ch. 1419.)

23 Source Law

24 Art. 20A.01B. In this Act, terms defined by
25 Section 843.002, Insurance Code, have the meanings
26 assigned by that section.

27 Revised Law

28 Sec. 258.002. MAINTENANCE TAX IMPOSED. A per capita
29 maintenance tax is imposed on each authorized health maintenance
30 organization with gross revenues subject to taxation under Section
31 258.004. The tax required by this chapter is in addition to other
32 taxes imposed that are not in conflict with this chapter. (V.T.I.C.
33 Art. 20A.33, Secs. (d) (part), (e).)

34 Source Law

35 (d) . . . a per capita [maintenance tax] to be
36 paid . . . on the . . . gross revenues . . .
37 [collected] by all authorized health maintenance
38 organizations [issuing such coverages]

39 (e) The tax required by this section is in
40 addition to all other taxes now imposed or that may be

1 subsequently imposed and that are not in conflict with
2 this section.

3 Revised Law

4 Sec. 258.003. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The
5 rate of assessment set by the commissioner may not exceed \$2 per
6 enrollee.

7 (b) The commissioner shall annually adjust the rate of
8 assessment of the per capita maintenance tax so that the tax imposed
9 that year, together with any unexpended funds produced by the tax,
10 produces the amount the commissioner determines is necessary to pay
11 the expenses during the succeeding year of regulating health
12 maintenance organizations.

13 (c) The rate of assessment may differ between basic health
14 care plans, limited health care service plans, and single health
15 care service plans and must equitably reflect any differences in
16 regulatory resources attributable to each type of plan. (V.T.I.C.
17 Art. 20A.33, Secs. (d) (part), (f) (part).)

18 Source Law

19 (d) . . . The rate of assessment may not exceed
20 \$2 for each enrollee. The rate of assessment may
21 differ between basic health care plans, limited health
22 care service plans, and single health care service
23 plans and shall equitably reflect any differences in
24 regulatory resources attributable to each type of
25 plan. . . .

26 (f) The commissioner, after taking into account
27 the unexpended funds produced by this tax, if any,
28 shall adjust the rate of assessment each year to
29 produce the amount of funds that it estimates will be
30 necessary to pay all the expenses of regulating health
31 maintenance organizations during the succeeding
32 year. . . .

33 Revised Law

34 Sec. 258.004. REVENUES SUBJECT TO TAXATION; LIMIT. (a) A
35 health maintenance organization shall pay per capita maintenance
36 taxes under this chapter on the correctly reported gross revenues
37 collected from issuing health maintenance certificates or
38 contracts in this state.

39 (b) The amount of maintenance tax assessed may not be
40 computed based on enrollees who as individual certificate holders
41 or their dependents are covered by a master group policy paid for by

1 revenues received from this state or the United States for
2 insurance contracted for by this state or the United States:

3 (1) in accordance with or in furtherance of Title 2,
4 Human Resources Code, or the Social Security Act (42 U.S.C. Section
5 301 et seq.); or

6 (2) to provide welfare benefits to designated welfare
7 recipients. (V.T.I.C. Art. 20A.33, Sec. (d) (part).)

8 Source Law

9 (d) . . . [a per capita maintenance tax to be
10 paid] on . . . [the] correctly reported [gross
11 revenues] for the issuance of health maintenance
12 certificates or contracts collected [by all authorized
13 health maintenance organizations] issuing such
14 coverages in this state. . . . For purposes of this
15 section, the amount of maintenance tax assessed may
16 not be computed on enrollees who as individual
17 certificate holders or their dependents are covered by
18 a master group policy paid for by revenues received
19 from this state or the United States for insurance
20 contracted for by this state or the United States for
21 the purpose of providing welfare benefits to
22 designated welfare recipients or for insurance
23 contracted for by this state or the United States in
24 accordance with or in furtherance of Title 2, Human
25 Resources Code, or the federal Social Security Act (42
26 U.S.C. Section 301 et seq.).

27 Revised Law

28 Sec. 258.005. MAINTENANCE TAX DUE DATES. (a) The health
29 maintenance organization shall pay the maintenance tax annually or
30 semiannually.

31 (b) The comptroller may require semiannual or other
32 periodic payment only from a health maintenance organization whose
33 maintenance tax liability under this chapter for the previous year
34 was at least \$2,000. (V.T.I.C. Art. 20A.33, Secs. (d) (part),
35 (h).)

36 Source Law

37 (d) . . . [tax to be paid on] an annual or
38 semiannual basis,

39 (h) The comptroller may collect the tax assessed
40 under this section on a semiannual or other periodic
41 basis from those health maintenance organizations
42 whose tax liability under this section for the
43 previous year was \$2,000 or more.

44 CHAPTER 259. THIRD-PARTY ADMINISTRATORS

45 Sec. 259.001. DEFINITIONS 119

1 Sec. 259.002. MAINTENANCE TAX IMPOSED 119
2 Sec. 259.003. MAXIMUM RATE; ANNUAL ADJUSTMENT. 120
3 Sec. 259.004. ADMINISTRATIVE AND SERVICE FEES SUBJECT TO
4 TAXATION. 120
5 Sec. 259.005. MAINTENANCE TAX DUE DATES 120

6 CHAPTER 259. THIRD-PARTY ADMINISTRATORS

7 Revised Law

8 Sec. 259.001. DEFINITIONS. In this chapter:

9 (1) "Administrative or service fees" means all
10 consideration, fees, assessments, payments, reimbursements, dues,
11 and other compensation received for services as an administrator
12 during a calendar year. The term does not include sales
13 commissions.

14 (2) "Administrator" has the meaning assigned by
15 Section 4151.001. (V.T.I.C. Art. 21.07-6, Sec. 1(2); New.)

16 Source Law

17 (2) "Administrative or service fees" means
18 all consideration, fees, assessments, payments,
19 reimbursements, dues, and other compensation,
20 excluding sales commissions, received for services as
21 an administrator during a calendar year.

22 Revisor's Note

23 Section 21, V.T.I.C. Article 21.07-6, uses the
24 term "administrator." That term is defined for
25 purposes of that section by Section 1(1), V.T.I.C.
26 Article 21.07-6, revised in Section 4151.001. The
27 revised law is drafted accordingly.

28 Revised Law

29 Sec. 259.002. MAINTENANCE TAX IMPOSED. A maintenance tax
30 is imposed on each authorized administrator with administrative or
31 service fees subject to taxation under Section 259.004. The tax
32 required by this chapter is in addition to other taxes imposed that
33 are not in conflict with this chapter. (V.T.I.C. Art. 21.07-6,
34 Secs. 21(a) (part), (b).)

35 Source Law

36 (a) . . . [a maintenance tax] to be paid

1 on . . . administrative or service fees of all
2 administrators that are covered by certificates of
3 authority. . . .

4 (b) The tax required by this section is in
5 addition to all other taxes now imposed or that may be
6 subsequently imposed and that are not in conflict with
7 this section.

8 Revised Law

9 Sec. 259.003. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The
10 rate of assessment set by the commissioner may not exceed one
11 percent of the administrative or service fees subject to taxation
12 under Section 259.004.

13 (b) The commissioner shall annually adjust the rate of
14 assessment of the maintenance tax so that the tax imposed that year,
15 together with any unexpended funds produced by the tax, produces
16 the amount the commissioner determines is necessary to pay the
17 expenses of regulating administrators. (V.T.I.C. Art. 21.07-6,
18 Secs. 21(a) (part), (c) (part).)

19 Source Law

20 (a) . . . The rate of assessment may not exceed
21 one percent of the . . . [administrative or service
22 fees]

23 (c) The commissioner, after taking into account
24 the unexpended funds produced by this tax, if any,
25 shall adjust the rate of assessment each year to
26 produce the amount of funds that it estimates will be
27 necessary to pay all the expenses of regulating
28 administrators. . . .

29 Revised Law

30 Sec. 259.004. ADMINISTRATIVE AND SERVICE FEES SUBJECT TO
31 TAXATION. An administrator shall pay maintenance taxes under this
32 chapter on the administrator's correctly reported administrative
33 or service fees. (V.T.I.C. Art. 21.07-6, Sec. 21(a) (part).)

34 Source Law

35 (a) . . . [a maintenance tax to be paid
36 on . . . the] correctly reported [administrative or
37 service fees of all administrators]

38 Revised Law

39 Sec. 259.005. MAINTENANCE TAX DUE DATES. The
40 administrator shall pay the maintenance tax annually,
41 semiannually, or on another periodic basis, as determined by the
42 comptroller. (V.T.I.C. Art. 21.07-6, Sec. 21(a) (part).)

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Source Law

(a) . . . [tax to be paid on] an annual, semiannual, or other periodic basis, as determined by the comptroller. . . .

CHAPTER 260. NONPROFIT LEGAL SERVICES CORPORATIONS

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CHAPTER 260. NONPROFIT LEGAL SERVICES CORPORATIONS

Revised Law

Sec. 260.001. MAINTENANCE TAX IMPOSED. A maintenance tax is imposed on each nonprofit legal services corporation subject to Chapter 961 with gross revenues subject to taxation under Section 260.003. The tax required by this chapter is in addition to other taxes imposed that are not in conflict with this chapter. (V.T.I.C. Art. 23.08A, Secs. (a) (part), (b).)

Source Law

(a) . . . [a maintenance tax] to be paid by a nonprofit legal services corporation subject to Chapter 961 of this code on . . . gross revenues [received by all corporations issuing prepaid legal services contracts]

(b) The tax required by this article is in addition to all other taxes now imposed or that may be subsequently imposed and that are not in conflict with this article.

Revised Law

Sec. 260.002. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The rate of assessment set by the commissioner may not exceed one percent of the corporation's gross revenues subject to taxation under Section 260.003.

(b) The commissioner shall annually adjust the rate of assessment of the maintenance tax so that the tax imposed that year, together with any unexpended funds produced by the tax, produces the amount the commissioner determines is necessary to pay the expenses during the succeeding year of regulating nonprofit legal services corporations. (V.T.I.C. Art. 23.08A, Secs. (a) (part),

1 (c) (part).)

2 Source Law

3 (a) . . . The rate of assessment may not exceed
4 one percent of the . . . [gross revenues]

5 (c) The commissioner, after taking into account
6 the unexpended funds produced by this tax, if any,
7 shall adjust the rate of assessment each year to
8 produce the amount of funds that it estimates will be
9 necessary to pay all the expenses of regulating
10 nonprofit legal services corporations during the
11 succeeding year. . . .

12 Revised Law

13 Sec. 260.003. REVENUES SUBJECT TO TAXATION. A corporation
14 shall pay maintenance taxes under this chapter on the correctly
15 reported gross revenues received from issuing prepaid legal
16 services contracts in this state. (V.T.I.C. Art. 23.08A, Sec. (a)
17 (part).)

18 Source Law

19 (a) . . . [a maintenance tax to be paid . . . on
20 . . . the] correctly reported [gross revenues]
21 received by all corporations issuing prepaid legal
22 services contracts in this state. . . .

23 Revised Law

24 Sec. 260.004. MAINTENANCE TAX DUE DATES; RULES. (a) The
25 corporation shall pay the maintenance tax annually or semiannually.

26 (b) The comptroller may require semiannual payments only
27 from a corporation whose maintenance tax liability under this
28 chapter for the previous tax year was at least \$2,000.

29 (c) The comptroller may adopt reasonable rules to implement
30 semiannual payments that the comptroller considers advisable.
31 (V.T.I.C. Art. 23.08A, Secs. (a) (part), (f).)

32 Source Law

33 (a) . . . [tax to be paid . . . on] an annual or
34 semiannual basis. . . .

35 (f) The comptroller may elect to collect on a
36 semiannual basis the tax assessed under this article
37 only from insurers whose tax liability under this
38 article for the previous tax year was \$2,000 or more.
39 The comptroller may prescribe and adopt reasonable
40 rules to implement such payments as it deems
41 advisable, not inconsistent with this article.

1 Revisor's Note

2 Section (f), V.T.I.C. Article 23.08A, authorizes
3 the comptroller to "prescribe and adopt . . . rules
4 . . . not inconsistent with this article." The
5 revised law omits "prescribe" as unnecessary because
6 its meaning is included in the meaning of "adopt." The
7 revised law also omits "not inconsistent with this
8 article" as unnecessary because the comptroller does
9 not have the authority to adopt rules that are
10 inconsistent with a state statute.

11 Revised Law

12 Sec. 260.005. APPLICABILITY OF OTHER LAW. Sections
13 201.001 and 201.002 apply to taxes collected under this chapter.
14 (V.T.I.C. Art. 23.08A, Sec. (e).)

15 Source Law

16 (e) Article 1.31A of this code applies to taxes
17 collected under this article.

18 CHAPTER 261. TEXAS INSURANCE EXCHANGE

19 Sec. 261.001. DEFINITION. 123
20 Sec. 261.002. MAINTENANCE TAX IMPOSED 123
21 Sec. 261.003. MAXIMUM RATE; ANNUAL ADJUSTMENT. 124
22 Sec. 261.004. PREMIUMS SUBJECT TO TAXATION 124
23 Sec. 261.005. MAINTENANCE TAX DUE DATES 125

24 CHAPTER 261. TEXAS INSURANCE EXCHANGE

25 Revised Law

26 Sec. 261.001. DEFINITION. In this chapter, "exchange"
27 means the Texas Insurance Exchange. (V.T.I.C. Art. 1.14-3, Sec.
28 1(1).)

29 Source Law

30 Art. 1.14-3
31 Sec. 1. In this article:
32 (1) "Exchange" means the Texas Insurance
33 Exchange.

34 Revised Law

35 Sec. 261.002. MAINTENANCE TAX IMPOSED. A maintenance tax
36 is imposed on the gross premiums paid through the exchange and

1 subject to taxation under Section 261.004. (V.T.I.C. Art. 1.14-3,
2 Sec. 8(a) (part).)

3 Source Law

4 (a) . . . [a maintenance tax] to be paid on
5 . . . gross premiums . . . paid through the
6 exchange. . . .

7 Revised Law

8 Sec. 261.003. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The
9 rate of assessment set by the commissioner may not exceed one
10 percent of the gross premiums subject to taxation under Section
11 261.004.

12 (b) The commissioner shall annually adjust the rate of
13 assessment of the maintenance tax so that the tax imposed that year,
14 together with any unexpended funds produced by the tax, produces
15 the amount the commissioner determines is necessary to pay the
16 expenses during the succeeding year of regulating all classes of
17 insurance specified under Article 1.14-3. (V.T.I.C. Art. 1.14-3,
18 Secs. 8(a) (part), (b) (part).)

19 Source Law

20 (a) . . . The rate of assessment may not exceed
21 one percent of the . . . [gross premiums]
22 (b) After taking into account the unexpended
23 funds produced by this tax, if any, the commissioner
24 shall adjust the rate of assessment each year to
25 produce the amount of funds that the commissioner
26 estimates will be necessary to pay all the expenses of
27 regulating all classes of insurance covered by this
28 article during the succeeding year. . . .

29 Revised Law

30 Sec. 261.004. PREMIUMS SUBJECT TO TAXATION. The exchange
31 shall pay maintenance taxes under this chapter on the correctly
32 reported gross premiums paid through the exchange on all classes of
33 insurance specified under Article 1.14-3. (V.T.I.C. Art. 1.14-3,
34 Sec. 8(a) (part).)

35 Source Law

36 (a) . . . [a maintenance tax to be paid on . . .
37 the] correctly reported [gross premiums] on all
38 classes of insurance covered by this article and [paid
39 through the exchange.] . . .

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Revised Law

Sec. 261.005. MAINTENANCE TAX DUE DATES. The exchange shall pay the maintenance tax annually, semiannually, or on another periodic basis, as determined by the comptroller. (V.T.I.C. Art. 1.14-3, Sec. 8(a) (part).)

Source Law

(a) . . . [tax to be paid on] an annual, semiannual, or other periodic basis, as determined by the comptroller. . . .

[Chapters 262-270 reserved for expansion]

SUBTITLE D. TITLE INSURANCE MAINTENANCE FEES

CHAPTER 271. TITLE INSURANCE MAINTENANCE FEES

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CHAPTER 271. TITLE INSURANCE MAINTENANCE FEES

Revised Law

Sec. 271.001. APPLICABILITY OF CERTAIN DEFINITIONS. In this chapter, a term defined by Chapter 2501 has the meaning assigned by that chapter. (New.)

Revisor's Note

This chapter is derived from V.T.I.C. Article 9.46, part of the Texas Title Insurance Act. The definitional provisions of the Texas Title Insurance Act that apply throughout that act are revised in

1 Chapter 2501 of this code. Accordingly, this chapter
2 includes a reference to the applicability of the
3 definitions provided by that chapter of this code.

4 Revised Law

5 Sec. 271.002. MAINTENANCE FEE IMPOSED. (a) A maintenance
6 fee is imposed on each insurer with gross premiums subject to
7 assessment under Section 271.006.

8 (b) The maintenance fee is not a tax and shall be reported
9 and paid separately from premium and retaliatory taxes. (V.T.I.C.
10 Art. 9.46, Sec. (a) (part), as amended Acts 73rd Leg., R.S., Ch.
11 685, Sec. 3.18; V.T.I.C. Art. 9.46 (part), as amended Acts 73rd
12 Leg., R.S., Ch. 486, Sec. 6.04.)

13 Source Law

14 Art. 9.46. [as amended Acts 73rd Leg., R.S., Ch.
15 685] (a) . . . a maintenance fee to be paid
16 on . . . gross . . . premiums of all authorized
17 insurers [writing title insurance] This fee
18 is not a tax and shall be reported and paid separately
19 from premium and retaliatory taxes. . . .

20 Art. 9.46. [as amended Acts 73rd Leg., R.S., Ch.
21 486] . . . shall charge an . . . maintenance
22 fee . . . [not to exceed one percent of] all amounts
23 defined to be premium in this chapter. This fee is not
24 a tax and shall be reported and paid separately from
25 premium and retaliatory taxes. . . .

26 Revised Law

27 Sec. 271.003. DUPLICATION OF ASSESSMENT PROHIBITED WITH
28 RESPECT TO TITLE INSURANCE AGENTS. The maintenance fee is included
29 in the division of premiums and may not be separately charged to a
30 title insurance agent. (V.T.I.C. Art. 9.46, Sec. (a) (part), as
31 amended Acts 73rd Leg., R.S., Ch. 685, Sec. 3.18; V.T.I.C.
32 Art. 9.46 (part), as amended Acts 73rd Leg., R.S., Ch. 486, Sec.
33 6.04.)

34 Source Law

35 Art. 9.46. [as amended Acts 73rd Leg., R.S., Ch.
36 685] (a) . . . The fee is included in the division of
37 premium and may not be separately charged to the title
38 insurance agent. . . .

39 Art. 9.46. [as amended Acts 73rd Leg., R.S., Ch.
40 486] . . . The fee is included in the division of
41 premiums and shall not be separately charged to the
42 title insurance agent. . . .

1 Revised Law

2 Sec. 271.004. DETERMINING RATE OF ASSESSMENT. (a) The
3 commissioner shall annually determine the rate of assessment of the
4 maintenance fee.

5 (b) In determining the rate of assessment, the commissioner
6 shall consider the requirement to reimburse the appropriate portion
7 of the general revenue fund under Section 201.052. (V.T.I.C.
8 Art. 9.46, Secs. (a) (part), (b) (part), as amended Acts 73rd Leg.,
9 R.S., Ch. 685, Sec. 3.18; V.T.I.C. Art. 9.46 (part), as amended
10 Acts 73rd Leg., R.S., Ch. 486, Sec. 6.04.)

11 Source Law

12 Art. 9.46. [as amended Acts 73rd Leg., R.S., Ch.
13 685] (a) The State of Texas by and through the
14 commissioner shall annually determine the rate of
15 assessment of [a maintenance fee]

16 (b) . . . In making an estimate under this
17 subsection, the commissioner shall take into account
18 the requirement that the general revenue fund be
19 reimbursed under Article 4.19 of this code.

20 Art. 9.46. [as amended Acts 73rd Leg., R.S., Ch.
21 486] The State of Texas by and through the State Board
22 of Insurance . . . [an . . . maintenance fee] . . .
23 The State Board of Insurance shall determine the rate
24 of assessment and

25 Revisor's Note

26 Section (b), V.T.I.C. Article 9.46, as amended by
27 Section 3.18, Chapter 685, Acts of the 73rd
28 Legislature, Regular Session, 1993, refers to a
29 required reimbursement of "the general revenue
30 fund . . . under Article 4.19," revised as Section
31 201.052 of this code. V.T.I.C. Article 4.19 requires
32 that the Texas Department of Insurance reimburse the
33 general revenue fund for the amount of the
34 comptroller's expenses in administering the collection
35 of insurance taxes, with the amount of the
36 reimbursement transferred from "the Texas Department
37 of Insurance operating fund to the general revenue
38 fund." Because the Texas Department of Insurance
39 operating fund has been converted to an account in the

1 general revenue fund, the revised law throughout this
2 chapter substitutes a requirement that "the
3 appropriate portion of the general revenue fund" be
4 reimbursed. This substitution reflects the clear
5 intent of the legislature that money be transferred
6 from the Texas Department of Insurance operating
7 account to a portion of the general revenue fund from
8 which the money may be appropriated to pay for the
9 comptroller's expenses incurred in performing duties
10 under the Insurance Code. It is clear from the
11 reference to a reimbursement "under Article 4.19" in
12 Section (b) that the intent of the legislature is for
13 Article 4.19 to apply to the revised law, even though
14 the revised law concerns a maintenance fee rather than
15 a maintenance tax.

16 Revised Law

17 Sec. 271.005. MAXIMUM RATE; ANNUAL ADJUSTMENT. (a) The
18 rate of assessment set by the commissioner may not exceed one
19 percent of the gross premiums subject to assessment under Section
20 271.006.

21 (b) The commissioner shall annually adjust the rate of
22 assessment of the maintenance fee so that the fee imposed that year,
23 together with any unexpended funds produced by the fee, produces
24 the amount the commissioner determines is necessary to pay the
25 expenses during the succeeding year of regulating title insurance.
26 (V.T.I.C. Art. 9.46, Secs. (a) (part), (b) (part), as amended Acts
27 73rd Leg., R.S., Ch. 685, Sec. 3.18; V.T.I.C. Art. 9.46 (part), as
28 amended Acts 73rd Leg., R.S., Ch. 486, Sec. 6.04.)

29 Source Law

30 Art. 9.46. [as amended Acts 73rd Leg., R.S., Ch.
31 685] (a) . . . The rate of assessment may not exceed
32 one percent of the . . . [gross . . . premiums]
33 (b) The commissioner, after taking into account
34 the unexpended funds produced by this fee, if any,
35 shall adjust the rate of assessment each year to
36 produce the amount of funds that it estimates will be
37 necessary to pay all the expenses of regulating title
38 insurance during the succeeding year. . . .

1 balance.

2 Section 312.014(b), Government Code, applicable
3 to Article 9.46, provides that if amendments to the
4 same statute are enacted during the same session of the
5 legislature, one amendment without reference to the
6 other, the amendments shall be harmonized, if
7 possible, so that effect may be given to each. If the
8 amendments are irreconcilable, the latest in date of
9 enactment prevails.

10 The amendments made by Chapters 486 and 685 are
11 irreconcilable in that Chapter 486 requires the State
12 Board of Insurance to collect the maintenance fee.
13 Chapter 685, however, requires the comptroller to
14 collect that fee.

15 Section 312.014(d), Government Code, provides
16 that the date of enactment of a statute is the date on
17 which the last legislative vote was taken on the bill
18 enacting the statute. The date on which the last
19 legislative vote was taken on the bill enacting
20 Chapter 486 was May 24, 1993. The date on which the
21 last legislative vote was taken on the bill enacting
22 Chapter 685 was May 30, 1993. Therefore, according to
23 Section 312.014(b), Government Code, the amendments to
24 Article 9.46 by Chapter 685 are the latest in date of
25 enactment and prevail over the amendments by Chapter
26 486 to the extent that the chapters cannot be
27 harmonized. The revised law reflects the amendments
28 made to Article 9.46 by Chapter 685. The omitted law
29 reads:

30 Art. 9.46. [as amended Acts 73rd
31 Leg., R.S., Ch. 486] . . . [The State
32 Board of Insurance shall] . . . collect a
33 maintenance fee

34 Revised Law

35 Sec. 271.008. DUTY TO ADVISE COMPTROLLER OF RATE. The

1 commissioner shall advise the comptroller of the applicable rate of
2 assessment of the maintenance fee not later than the 45th day before
3 the due date of the maintenance fee return for the period for which
4 that fee is due. (V.T.I.C. Art. 9.46, Sec. (e) (part), as amended
5 Acts 73rd Leg., R.S., Ch. 685, Sec. 3.18.)

6 Source Law

7 (e) [as amended Acts 73rd Leg., R.S., Ch. 685]
8 The commissioner shall advise the comptroller of the
9 applicable rate of assessment no later than the date 45
10 days prior to the due date of the maintenance fee
11 return for the period for which such fees are
12 due. . . .

13 Revised Law

14 Sec. 271.009. EFFECT OF LATE ADVISEMENT OF
15 RATE. (a) Except as provided by Subsection (b), if the
16 commissioner does not advise the comptroller of the applicable rate
17 of assessment of the maintenance fee by the date required by Section
18 271.008, the rate of assessment is the rate imposed in the preceding
19 period.

20 (b) If the commissioner advises the comptroller of the
21 applicable rate of assessment after the fee has been assessed, the
22 comptroller shall:

23 (1) advise each insurer in writing of the amount of any
24 additional fees due; or

25 (2) refund any excess fees paid. (V.T.I.C. Art. 9.46,
26 Sec. (e) (part), as amended Acts 73rd Leg., R.S., Ch. 685, Sec.
27 3.18.)

28 Source Law

29 (e) [as amended Acts 73rd Leg., R.S., Ch.
30 685] . . . If the commissioner has not advised the
31 comptroller of the applicable rate by such date, the
32 applicable rate shall be the rate applied in the
33 previous period. If the commissioner advises the
34 comptroller of the applicable rate of assessment after
35 maintenance fees have been assessed pursuant to this
36 subsection, the comptroller shall:

37 (1) advise each insurer in writing of the
38 amount of any additional maintenance fees due; or

39 (2) refund any excess maintenance fees
40 paid.

41 Revised Law

42 Sec. 271.010. DEPOSIT OF MAINTENANCE FEES. (a) The

1 comptroller shall deposit maintenance fees collected under this
2 chapter in the general revenue fund to be reallocated to the Texas
3 Department of Insurance operating account.

4 (b) Amounts in the Texas Department of Insurance operating
5 account may be transferred to the appropriate portion of the
6 general revenue fund in accordance with Section 201.052. (V.T.I.C.
7 Art. 9.46, Sec. (c), as amended Acts 73rd Leg., R.S., Ch. 685, Sec.
8 3.18; V.T.I.C. Art. 9.46 (part), as amended Acts 73rd Leg., R.S.,
9 Ch. 486, Sec. 6.04.)

10 Source Law

11 (c) [as amended Acts 73rd Leg., R.S., Ch. 685]
12 The fees collected shall be deposited in the State
13 Treasury to the credit of the general revenue fund to
14 be reallocated to the Texas Department of Insurance
15 operating fund and shall be spent as authorized by
16 legislative appropriation on warrants issued by the
17 comptroller pursuant to duly certified requisitions of
18 the commissioner. Amounts reallocated to the Texas
19 Department of Insurance operating fund under this
20 subsection may be transferred to the general revenue
21 fund in accordance with Article 4.19 of this code.

22 Art. 9.46. [as amended Acts 73rd Leg., R.S., Ch.
23 486] . . . The fees collected shall be deposited in
24 the State Treasury to the credit of the State Board of
25 Insurance operating fund and shall be spent as
26 authorized by legislative appropriation only on
27 warrants issued by the comptroller of public accounts
28 pursuant to duly certified requisitions of the State
29 Board of Insurance. . . .

30 Revisor's Note

31 (1) Section (c), V.T.I.C. Article 9.46, as
32 amended by Section 3.18, Chapter 685, Acts of the 73rd
33 Legislature, Regular Session, 1993, states that
34 maintenance fees shall be "deposited in the State
35 Treasury to the credit of the general revenue fund to
36 be reallocated to the Texas Department of Insurance
37 operating fund." V.T.I.C. Article 9.46, as amended by
38 Section 6.04, Chapter 486, Acts of the 73rd
39 Legislature, Regular Session, 1993, states that
40 maintenance fees shall be "deposited in the State
41 Treasury to the credit of the State Board of Insurance
42 operating fund." Under Chapter 4, Acts of the 72nd

1 Legislature, 1st Called Session, 1991, the Texas
2 Department of Insurance operating fund (the later name
3 of the State Board of Insurance operating fund) was
4 converted to an account in the general revenue fund.
5 The revised law is drafted accordingly.

6 (2) Section (c), V.T.I.C. Article 9.46, as
7 amended by Section 3.18, Chapter 685, Acts of the 73rd
8 Legislature, Regular Session, 1993, states that
9 maintenance fees shall be "spent as authorized by
10 legislative appropriation on warrants issued by the
11 comptroller pursuant to duly certified requisitions of
12 the commissioner." V.T.I.C. Article 9.46, as amended
13 by Section 6.04, Chapter 486, Acts of the 73rd
14 Legislature, Regular Session, 1993, states that
15 maintenance fees shall be "spent as authorized by
16 legislative appropriation only on warrants issued by
17 the comptroller of public accounts pursuant to duly
18 certified requisitions of the State Board of
19 Insurance." The revised law omits as unnecessary that
20 part of the provision relating to the expenditure of
21 money as authorized by legislative appropriation
22 because Section 6, Article VIII, Texas Constitution,
23 provides that "[n]o money shall be drawn from the
24 Treasury but in pursuance of specific appropriations
25 made by law." The revised law also omits as
26 unnecessary that part of the provision relating to
27 warrants issued by the comptroller pursuant to
28 certified requisitions of the commissioner because it
29 is substantively duplicative of provisions contained
30 in Chapter 2103, Government Code, which is a
31 comprehensive law covering procedures for withdrawing
32 money from the state treasury.

33 Revised Law

34 Sec. 271.011. MAINTENANCE FEE DUE DATES. (a) The insurer

1 shall pay the maintenance fee on an annual, semiannual, or other
2 periodic basis, as determined by the comptroller.

3 (b) The comptroller may require semiannual or other
4 periodic payment only from an insurer whose maintenance fee
5 liability under this chapter for the preceding year was at least
6 \$2,000. (V.T.I.C. Art. 9.46, Secs. (a) (part), (d), as amended
7 Acts 73rd Leg., R.S., Ch. 685, Sec. 3.18.)

8 Source Law

9 Art. 9.46. [as amended Acts 73rd Leg., R.S., Ch.
10 685] (a) . . . [fee be paid on] an annual,
11 semiannual, or other periodic basis, as determined by
12 the comptroller. . . .

13 (d) The comptroller may elect to collect on a
14 semiannual or other periodic basis the fee assessed
15 under this article only from insurers whose liability
16 under this article for the previous year was \$2,000 or
17 more.

18 Revisor's Note

19 V.T.I.C. Article 9.46, as amended by Section
20 6.04, Chapter 486, Acts of the 73rd Legislature,
21 Regular Session, 1993, provides for assessment of an
22 "annual" maintenance fee and provides for collection
23 of the fee from certain insurers by the State Board of
24 Insurance "on a semiannual basis." Sections (a) and
25 (d), V.T.I.C. Article 9.46, as amended by Section
26 3.18, Chapter 685, Acts of the 73rd Legislature,
27 Regular Session, 1993, however, provide for assessment
28 of a maintenance fee "on an annual, semiannual, or
29 other periodic basis, as determined by the
30 comptroller" and provide for collection of the fee
31 from certain insurers by the comptroller "on a
32 semiannual or other periodic basis." For the reasons
33 described by the revisor's note to Section 271.007, the
34 revised law reflects the amendments made to Article
35 9.46 by Chapter 685. The omitted law reads:

36 Art. 9.46. [as amended Acts 73rd
37 Leg., R.S., Ch. 486] . . . [an] annual
38 [maintenance fee] . . . The State Board of
39 Insurance shall collect on a semiannual

1 basis the fee assessed under this article
2 only from insurers whose liability under
3 this article for the previous year was
4 \$2,000 or more. . . .

5 Revised Law

6 Sec. 271.012. RULES. The commissioner may adopt
7 reasonable rules to implement payments under this chapter.
8 (V.T.I.C. Art. 9.46 (part), as amended Acts 73rd Leg., R.S., Ch.
9 486, Sec. 6.04.)

10 Source Law

11 Art. 9.46. [as amended Acts 73rd Leg., R.S., Ch.
12 486] . . . The State Board of Insurance may prescribe
13 and adopt reasonable rules to implement such payments
14 as it deems advisable, not inconsistent with this
15 article.

16 Revisor's Note

17 V.T.I.C. Article 9.46, as amended by Section
18 6.04, Chapter 486, Acts of the 73rd Legislature,
19 Regular Session, 1993, authorizes the commissioner to
20 "prescribe and adopt . . . rules . . . not
21 inconsistent with this article." The revised law
22 omits "prescribe" as unnecessary because its meaning
23 is included in the meaning of "adopt." The revised law
24 also omits "not inconsistent with this article" as
25 unnecessary because the commissioner does not have the
26 authority to adopt rules that are inconsistent with a
27 state statute.

28 [Chapters 272-280 reserved for expansion]

29 SUBTITLE E. OTHER TAXES

30 CHAPTER 281. RETALIATORY PROVISIONS

31 SUBCHAPTER A. RETALIATORY TAXES AND OTHER CHARGES

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9 CHAPTER 281. RETALIATORY PROVISIONS

10 SUBCHAPTER A. RETALIATORY
11 TAXES AND OTHER CHARGES

12 Revised Law

13 Sec. 281.001. DEFINITIONS. In this subchapter:
14 (1) "Domestic insurer" means an insurer organized in
15 this state.
16 (2) "Foreign insurer" means an insurer organized in
17 another state.
18 (3) "Tax or other charge" includes:
19 (A) a tax, including an income, corporate
20 franchise, or maintenance tax;
21 (B) a fee, including a regulatory fee similar to
22 a maintenance tax;
23 (C) a license;
24 (D) a fine;
25 (E) a penalty;
26 (F) a deposit requirement; and
27 (G) any other obligation. (V.T.I.C. Art. 21.46,
28 Sec. 1(a) (part).)

29 Source Law

30 Art. 21.46
31 Sec. 1. (a) Whenever . . . any taxes,
32 including maintenance or similar regulatory fees,
33 income and corporate franchise, licenses, fees, fines,
34 penalties, deposit requirements or other obligations
35 . . . [are imposed upon] any insurance company that is
36 organized in this State and . . . [are in excess of]
37 . . . the taxes, including maintenance or similar
38 regulatory fees, income and corporate franchise,

1 licenses, fees, fines, penalties, deposit
2 requirements or other obligations, . . . [directly
3 imposed upon] a similar insurance company of such
4 other state or

5 Revisor's Note

6 The definitions of "domestic insurer," "foreign
7 insurer," and "tax or other charge" are added to the
8 revised law for drafting convenience and to eliminate
9 frequent, unnecessary repetition of the substance of
10 the defined terms.

11 Revised Law

12 Sec. 281.002. TREATMENT OF ALIEN INSURER AS FOREIGN
13 INSURER. For purposes of this subchapter, an alien insurer is
14 considered to be organized in the state designated by the insurer in
15 which the insurer:

16 (1) has established its principal office or agency in
17 the United States;

18 (2) maintains the greatest amount of its assets held
19 in trust or on deposit for the security of its policyholders or
20 policyholders and creditors in the United States; or

21 (3) was admitted to engage in business in the United
22 States. (V.T.I.C. Art. 21.46, Sec. 1(c).)

23 Source Law

24 (c) For the purpose of this Section, an alien
25 insurer shall be deemed a company of the State
26 designated by it wherein it:

27 (1) has established its principal office
28 or agency in the United States;

29 (2) maintains the largest amount of its
30 assets held in trust or on deposit for the security of
31 its policyholders or policyholders and creditors in
32 the United States; or

33 (3) was admitted to do business in the
34 United States.

35 Revised Law

36 Sec. 281.003. EXCEPTION. This subchapter does not apply to
37 a person, company, firm, association, group, corporation, or
38 insurance organization of any kind from another state that engages
39 in business in this state if:

40 (1) at least 15 percent of the voting stock of the
41 person, company, firm, association, group, corporation, or

1 insurance organization is owned by a corporation organized under
2 the laws of and domiciled in this state; and

3 (2) the person, company, firm, association, group,
4 corporation, or insurance organization met the requirements of
5 Subdivision (1) before January 30, 1957. (V.T.I.C. Art. 21.46,
6 Sec. (f).)

7 Source Law

8 (f) The provisions of this Act shall not apply
9 to a company of any other state doing business in this
10 State if fifteen per cent (15%) or more of the voting
11 stock of said company is owned by a corporation
12 organized under the laws of this State, and domiciled
13 in this State; however, the prior provisions of this
14 Act shall apply without exception to any and all person
15 or persons, company or companies, firm or firms,
16 association or associations, group or groups,
17 corporation or corporations, or any insurance
18 organization or organizations of any kind, which did
19 not qualify as a matter of fact, under the exception of
20 this paragraph, on or before January 29, 1957.

21 Revisor's Note

22 Section 1(f), V.T.I.C. Article 21.46, as added by
23 Chapter 396, Acts of the 55th Legislature, Regular
24 Session, 1957, refers to "provisions of this Act" that
25 do not apply to certain insurers. Section 2, V.T.I.C.
26 Article 21.46, as added by Section 20.24, Chapter 685,
27 Acts of the 73rd Legislature, Regular Session, 1993,
28 and revised in Subchapter B of this chapter, requires
29 the Texas Department of Insurance to apply certain
30 penalties to insurers "without exception or
31 exclusion." Because Section 2 specifically precludes
32 any exceptions to its application, the revised law
33 limits the scope of the earlier exception created by
34 Chapter 396, Acts of the 55th Legislature, Regular
35 Session, 1957, to Subchapter A only.

36 Revised Law

37 Sec. 281.004. RETALIATORY TAXES OR OTHER CHARGES,
38 PROHIBITIONS, AND RESTRICTIONS. (a) The comptroller shall impose
39 and collect a tax or other charge or a prohibition or restriction on
40 a foreign insurer authorized to engage in business in this state if:

1 (1) the foreign insurer's state of organization by law
2 imposes a tax or other charge or a prohibition or restriction on a
3 similar domestic insurer that is or may be authorized to engage in
4 business in that other state; and

5 (2) the sum of the taxes or other charges,
6 prohibitions, and restrictions imposed by that other state is more
7 than the sum of the taxes or other charges, prohibitions, and
8 restrictions that this state directly imposes on the foreign
9 insurer.

10 (b) The comptroller shall impose and collect the tax or
11 other charge, prohibition, or restriction under Subsection (a) in
12 the same manner and for the same purpose as the foreign insurer's
13 state of organization.

14 (c) The sum of the taxes or other charges that this state
15 imposes on a foreign insurer under this subchapter may not exceed
16 the sum of the taxes or other charges imposed by the foreign
17 insurer's state of organization on a similar domestic insurer that
18 is or may be authorized to engage in business in that other state.
19 (V.T.I.C. Art. 21.46, Sec. 1(a).)

20 Source Law

21 Sec. 1. (a) Whenever by the laws of any other
22 state or territory of the United States any taxes,
23 including maintenance or similar regulatory fees,
24 income and corporate franchise, licenses, fees, fines,
25 penalties, deposit requirements or other obligations,
26 prohibitions or restrictions are imposed upon any
27 insurance company that is organized in this State and
28 licensed and is doing business or that may do business
29 in such other state or territory which, in the
30 aggregate are in excess of the aggregate of the taxes,
31 including maintenance or similar regulatory fees,
32 income and corporate franchise, licenses, fees, fines,
33 penalties, deposit requirements or other obligations,
34 prohibitions or restrictions directly imposed upon a
35 similar insurance company of such other state or
36 territory doing business in this State, the
37 comptroller shall impose upon and collect from any
38 similar company of such state or territory in the same
39 manner and for the same purpose, the same taxes,
40 licenses, fees, fines, penalties, deposit
41 requirements or other obligations, prohibitions or
42 restrictions; provided, however, the aggregate of
43 taxes, licenses, fees, fines, penalties or other
44 obligations imposed by this State pursuant to this
45 Article on an insurance company of another state or
46 territory shall not exceed the aggregate of such
47 charges imposed by such other state or territory on a

1 similar insurance company of this State that may be
2 licensed and doing business.

3 Revisor's Note

4 (1) Section 1(a), V.T.I.C. Article 21.46,
5 refers to an insurance company that is "licensed and
6 is doing business" in another state. Throughout this
7 chapter, the revised law substitutes "authorized to
8 engage in business" for "licensed and is doing
9 business" because states issue a variety of documents
10 that authorize companies to engage in business, and
11 the meaning of "authorized to engage in business"
12 includes the concept of holding a license, a
13 certificate of authority, or any other document issued
14 by a state agency or official to authorize that
15 activity.

16 (2) Section 1, V.T.I.C. Article 21.46, refers to
17 taxes or other charges imposed under "this Article."
18 Throughout this chapter, the revised law refers to
19 taxes or other charges imposed under "this subchapter"
20 instead because it is clear, in context, that Section
21 1, V.T.I.C. Article 21.46, refers only to charges
22 imposed under that section, and that law has been
23 revised as Subchapter A.

24 Revised Law

25 Sec. 281.005. EXCLUSION OF CERTAIN TAXES OR CHARGES. In
26 determining an insurer's taxes or other charges under this
27 subchapter, the comptroller may not consider:

- 28 (1) an ad valorem tax on property;
29 (2) a personal income tax;
30 (3) a sales tax;
31 (4) a surcharge that an insurer may recover directly
32 from policyholders; or

33 (5) an assessment for a special purpose, such as an
34 assessment for a guaranty association, high risk health pool, joint
35 underwriting association, or windstorm association, under the law

1 of this or another state. (V.T.I.C. Art. 21.46, Secs. 1(e), (g)
2 (part).)

3 Source Law

4 (e) The provisions of this Section shall not
5 apply to ad valorem taxes on real or personal property,
6 personal income taxes, sales taxes, or to surcharges
7 that insurers may recoup directly from policyholders.

8 (g) The provisions of this Section shall not
9 apply to special purpose assessments, such as guaranty
10 association assessments, high risk health pool
11 assessments, joint underwriting association (JUA)
12 assessments, windstorm association assessments, or
13 other similar assessments, both under the laws of this
14 State and under the laws of any other state or
15 territory. . . .

16 Revisor's Note

17 (1) Section 1(e), V.T.I.C. Article 21.46,
18 refers to "real or personal property." The revised law
19 omits "real or personal" because Section 311.005(4),
20 Government Code (Code Construction Act), applicable to
21 the revised law, defines "property" to mean "real and
22 personal property."

23 (2) Section 1(g), V.T.I.C. Article 21.46,
24 refers to laws of "any other state or territory."
25 Throughout this chapter, the revised law omits
26 references to "territory" as unnecessary because
27 Section 311.005(7), Government Code (Code
28 Construction Act), applicable to the revised law,
29 provides that "state," when referring to a part of the
30 United States, includes any state or territory of the
31 United States.

32 Revised Law

33 Sec. 281.006. TREATMENT OF CERTAIN TAX REDUCTIONS AND
34 CREDITS. (a) If another state by law reduces a tax rate or grants
35 a tax credit to a domestic insurer that makes an investment in or
36 maintains offices in that state or that meets a similar
37 requirement, the law that reduces the rate or grants the credit
38 shall be applied in the same manner in this state for the purpose of
39 determining the total taxes or other charges under this subchapter.

1 (b) For purposes of this subchapter, a tax offset or credit
2 related to an assessment described by Section 281.005 is considered
3 a tax paid in this or another state, as appropriate. (V.T.I.C.
4 Art. 21.46, Secs. 1(b), (g) (part).)

5 Source Law

6 (b) Whenever under the law of any state or
7 territory the rate of taxation is reduced or a tax
8 credit is granted to any such company making
9 investments in the state or territory, having
10 maintained offices in the state or territory, or
11 meeting some other similar requirements of the state
12 or territory, those laws shall be applied in the same
13 manner in this state in the determination of the
14 aggregate obligations under this Article.

15 (g) . . . Any tax offset or credit related to
16 such assessments that is offset or credited in
17 computing aggregate taxes under this Section for this
18 State and any other state or territory, shall, for
19 purposes of this Section, be treated as a tax paid both
20 under the laws of this State and under the laws of any
21 other state or territory.

22 Revised Law

23 Sec. 281.007. TAX REPORT; ADMINISTRATION AND COLLECTION OF
24 TAX. The comptroller shall prescribe a due date for filing a
25 report and paying a tax imposed under this subchapter. (V.T.I.C.
26 Art. 21.46, Sec. 1(d) (part).)

27 Source Law

28 (d) . . . The comptroller shall prescribe the
29 due date for the filing of the report and payment of
30 the tax under this Article. . . .

31 Revisor's Note

32 (1) Section 1(d), V.T.I.C. Article 21.46,
33 requires a tax collected under this subchapter to be
34 deposited to the credit of the general revenue fund.
35 The revised law omits that requirement because Section
36 404.094, Government Code, requires all money,
37 including the referenced taxes, that is collected or
38 received by a state agency to be deposited to the
39 credit of the general revenue fund, and it is not
40 necessary to repeat that requirement in the revised
41 law. The omitted law reads:

42 (d) A tax collected by the

1 comptroller under this Article shall be
2 deposited in the State Treasury to the
3 credit of the general revenue fund. . . .

4 (2) Section 1(d), V.T.I.C. Article 21.46,
5 states that the comptroller may adopt rules regarding
6 the administration and collection of taxes under that
7 article. The revised law omits that provision as
8 unnecessary because Section (c), V.T.I.C. Article
9 1.04D, revised in this code in Section 201.051,
10 authorizes the comptroller to adopt rules necessary to
11 administer and collect insurance taxes. The omitted
12 law reads:

13 (d) . . . The comptroller may adopt
14 rules concerning the administration and
15 collection of taxes under this Article.

16 [Sections 281.008-281.050 reserved for expansion]

17 SUBCHAPTER B. RETALIATORY PENALTIES OR OTHER OBLIGATIONS

18 Revised Law

19 Sec. 281.051. DEFINITIONS. In this subchapter:

20 (1) "Domestic insurer" and "foreign insurer" have the
21 meanings assigned by Section 281.001.

22 (2) "Penalty or other obligation" includes a sanction,
23 fine, financial, deposit, or regulatory requirement, and any other
24 obligation, prohibition, or restriction. (V.T.I.C. Art. 21.46,
25 Sec. 2 (part).)

26 Source Law

27 Sec. 2. [Should the insurance department . . .
28 of any other state . . . impose] any sanctions, fines,
29 penalties, financial or deposit requirements,
30 prohibitions, restrictions, regulatory requirements,
31 or other obligations of any kind upon any insurance
32 company organized or chartered in this state . . .
33 [the Texas Department of Insurance shall . . . impose
34 upon] any and all insurance companies organized or
35 chartered in such other state . . . the same
36 sanctions, fines, penalties, deposit requirements,
37 prohibitions, restrictions, or other
38 obligations

39 Revisor's Note

40 (1) The definitions of "domestic insurer" and
41 "foreign insurer" and the list of terms included in the
42 meaning of "penalty or other obligation" are added to

1 the revised law for drafting convenience and to
2 eliminate frequent, unnecessary repetition of the
3 substance of those terms.

4 (2) Section 2, V.T.I.C. Article 21.46, refers to
5 an "insurance company organized or chartered in this
6 state." The revised law incorporates that reference
7 into the definition of "domestic insurer" through the
8 cross-reference to the meaning assigned by Section
9 281.001, but omits the reference to "chartered"
10 because "chartered" is included in the meaning of
11 "organized."

12 Revised Law

13 Sec. 281.052. IMPOSITION OF PENALTY OR OTHER
14 OBLIGATION. (a) The Texas Department of Insurance shall impose a
15 penalty or other obligation on a foreign insurer authorized to
16 engage in the business of insurance in this state if:

17 (1) the insurance department or an insurance
18 regulatory official of the foreign insurer's state of organization
19 imposes a penalty or other obligation on any domestic insurer
20 authorized to engage in the business of insurance in that state; and

21 (2) the penalty or other obligation is imposed because
22 the Texas Department of Insurance did not:

23 (A) obtain or maintain accreditation
24 certification or a similar form of approval, compliance, or
25 acceptance from or as a member of the National Association of
26 Insurance Commissioners or a committee, task force, working group,
27 or advisory committee of the association; or

28 (B) comply with a model act, regulation, report,
29 or requirement of the National Association of Insurance
30 Commissioners or a committee, task force, working group, or
31 advisory committee of the association, including a market conduct,
32 financial examination, or annual financial statement.

33 (b) A penalty or other obligation imposed by the Texas
34 Department of Insurance on a foreign insurer under this section

1 must be the same as the penalty or other obligation imposed on the
2 domestic insurer by the insurance department or regulatory official
3 of the foreign insurer's state of organization. (V.T.I.C.
4 Art. 21.46, Sec. 2.)

5 Source Law

6 Sec. 2. Should the insurance department,
7 commissioner, director, or other similar insurance
8 regulatory official of any other state or territory of
9 the United States impose any sanctions, fines,
10 penalties, financial or deposit requirements,
11 prohibitions, restrictions, regulatory requirements,
12 or other obligations of any kind upon any insurance
13 company organized or chartered in this state and
14 licensed to transact business in such other state or
15 territory, because of the failure of the Texas
16 Department of Insurance to obtain, maintain, or
17 receive accreditation certification or any similar
18 form of approval, compliance, or acceptance from, by,
19 or as a member of the National Association of Insurance
20 Commissioners, or any committee, task force, working
21 group, or advisory committee thereof, or because of
22 the failure of the Texas Department of Insurance to
23 comply with any directive, financial annual statement
24 requirement, model act or regulation, market conduct
25 or financial examination report or requirement, or any
26 report of any kind of the National Association of
27 Insurance Commissioners, or any committee, task force,
28 working group, or advisory committee thereof, the
29 Texas Department of Insurance shall, without exception
30 or exclusion, impose upon any and all insurance
31 companies organized or chartered in such other state
32 or territory and licensed to do business in this state
33 the same sanctions, fines, penalties, deposit
34 requirements, prohibitions, restrictions, or other
35 obligations imposed upon the insurance company of this
36 state.

37 Revisor's Note

38 (1) Section 2, V.T.I.C. Article 21.46, refers to
39 an "insurance department, commissioner, director, or
40 other similar insurance regulatory official." The
41 revised law omits the references to "commissioner or
42 director" because those officials are included in the
43 meaning of "insurance regulatory official."

44 (2) Section 2, V.T.I.C. Article 21.46, refers to
45 a failure to "obtain . . . or receive accreditation
46 certification." The revised law omits the reference
47 to "receive" because "receive" is included in the
48 meaning of "obtain."

49 (3) Section 2, V.T.I.C. Article 21.46, refers to

1 a failure to comply with a "directive . . . or
2 requirement" of the National Association of Insurance
3 Commissioners. The revised law omits the reference to
4 "directive" because "directive" is included in the
5 meaning of "requirement."

6 TITLE 5. PROTECTION OF CONSUMER INTERESTS

7 SUBTITLE A. PUBLIC INSURANCE COUNSEL

8 CHAPTER 501. OFFICE OF PUBLIC INSURANCE COUNSEL

9 [Chapters 502-520 reserved for expansion]

10 SUBTITLE B. CONSUMER SERVICE PROVISIONS

11 CHAPTER 521. CONSUMER INFORMATION AND COMPLAINTS

12 CHAPTER 522. CONSUMER INFORMATION IN SPANISH

13 CHAPTER 523. MARKET ASSISTANCE PROGRAM FOR

14 RESIDENTIAL PROPERTY INSURANCE

15 [Chapters 524-540 reserved for expansion]

16 SUBTITLE C. DECEPTIVE, UNFAIR, AND PROHIBITED PRACTICES

17 CHAPTER 541. UNFAIR METHODS OF COMPETITION AND UNFAIR OR

18 DECEPTIVE ACTS OR PRACTICES

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21 CERTIFICATE OF MEMBERSHIP

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17	CHAPTER 651.	FINANCING OF INSURANCE PREMIUMS	
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19		SUBTITLE F. INSURANCE FRAUD	
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11 CHAPTER 501. OFFICE OF PUBLIC INSURANCE COUNSEL

12 SUBCHAPTER A. GENERAL PROVISIONS

13 Revised Law

14 Sec. 501.001. DEFINITION. In this chapter, "office" means
15 the office of public insurance counsel. (New.)

16 Revisor's Note

17 The definition of "office" is added to the
18 revised law for drafting convenience and to eliminate
19 frequent, unnecessary repetition of the substance of
20 the definition.

21 Revised Law

22 Sec. 501.002. OFFICE OF PUBLIC INSURANCE COUNSEL. The
23 independent office of public insurance counsel represents the
24 interests of insurance consumers in this state. (V.T.I.C.
25 Art. 1.35A, Sec. 1.)

26 Source Law

27 Art. 1.35A
28 Sec. 1. The independent office of public
29 insurance counsel is created to represent the
30 interests of insurance consumers in Texas.

31 Revisor's Note

32 Section 1, V.T.I.C. Article 1.35A, states that
33 "[t]he independent office of public insurance counsel
34 is created." The revised law omits the reference to
35 the creation of the office because that provision is

1 for program and facility accessibility.

2 Revisor's Note
3 (End of Subchapter)

4 (1) Section 3(b), V.T.I.C. Article 1.35A,
5 requires the office of public insurance counsel to
6 file an annual report accounting for all funds
7 received and disbursed by the office. The revised law
8 omits that provision because it was impliedly repealed
9 by Section 2101.011, Government Code, which
10 establishes a comprehensive uniform scheme for
11 reporting financial information by all state agencies.
12 The omitted law reads:

13 (b) The office of public insurance
14 counsel shall file annually with the
15 governor and the presiding officer of each
16 house of the legislature a complete and
17 detailed written report accounting for all
18 funds received and disbursed by the office
19 of public insurance counsel during the
20 preceding fiscal year. The annual report
21 must be in the form and reported in the time
22 provided by the General Appropriations Act.

23 (2) Section 3(c), V.T.I.C. Article 1.35A,
24 requires all money paid to the office of public
25 insurance counsel to be deposited in the state
26 treasury. The revised law omits that provision as
27 unnecessary. Section 404.094, Government Code,
28 requires all money collected or received by a state
29 agency to be deposited to the credit of the general
30 revenue fund. It is unnecessary to repeat that
31 requirement in this chapter. The omitted law reads:

32 (c) All money paid to the office of
33 public insurance counsel under this article
34 shall be deposited in the state treasury.

35 [Sections 501.006-501.050 reserved for expansion]

36 SUBCHAPTER B. PUBLIC COUNSEL

37 Revised Law

38 Sec. 501.051. APPOINTMENT; TERM. (a) The governor, with
39 the advice and consent of the senate, shall appoint a public counsel
40 to serve as the executive director of the office. The public

1 counsel serves a two-year term that expires on February 1 of each
2 odd-numbered year.

3 (b) The governor shall appoint the public counsel without
4 regard to the race, color, disability, sex, religion, age, or
5 national origin of the appointee. (V.T.I.C. Art. 1.35A, Secs.
6 2(a), (d), (e), 3(a) (part).)

7 Source Law

8 Sec. 2. (a) The governor with the advice and
9 consent of the senate shall appoint a public counsel
10 who shall serve as the executive director of the office
11 of public insurance counsel.

12 (d) Appointment of the public counsel shall be
13 made without regard to the race, color, handicap, sex,
14 religion, age, or national origin of the appointee.

15 (e) The public counsel shall serve for a term of
16 two years expiring on February 1 of each odd-numbered
17 year.

18 Sec. 3. (a) The public counsel, as executive
19 director of the office of public insurance counsel,
20

21 Revisor's Note

22 Section 2(d), V.T.I.C. Article 1.35A, refers to
23 "handicap." The revised law substitutes "disability"
24 for "handicap" because, in the context of this
25 section, "disability" and "handicap" are synonymous
26 and "disability" is the term used in most other
27 contexts, including the federal Americans with
28 Disabilities Act of 1990 (42 U.S.C. Section 12101 et
29 seq.).

30 Revised Law

31 Sec. 501.052. QUALIFICATIONS. To be eligible to serve as
32 public counsel, a person must:

- 33 (1) be licensed to practice law in this state;
34 (2) have demonstrated a strong commitment to and
35 involvement in efforts to safeguard the rights of the public; and
36 (3) possess the knowledge and experience necessary to
37 practice effectively in insurance proceedings. (V.T.I.C.
38 Art. 1.35A, Sec. 2(b).)

1 than compensation or reimbursement authorized by law for department
2 or office membership, attendance, or expenses. (V.T.I.C.
3 Art. 1.35A, Sec. 2(c).)

4 Source Law

5 (c) A person is not eligible for appointment as
6 public counsel if the person or the person's spouse:

7 (1) is employed by or participates in the
8 management of a business entity or other organization
9 regulated by the department or receiving funds from
10 the department;

11 (2) owns or controls, directly or
12 indirectly, more than a 10 percent interest in a
13 business entity or other organization regulated by the
14 department or receiving funds from the department or
15 the office of public insurance counsel; or

16 (3) uses or receives a substantial amount
17 of tangible goods, services, or funds from the
18 department or the office of public insurance counsel,
19 other than compensation or reimbursement authorized by
20 law for department or office of public insurance
21 counsel membership, attendance, or expenses.

22 Revised Law

23 Sec. 501.054. LOBBYING ACTIVITIES. A person may not serve
24 as public counsel or act as general counsel to the office if the
25 person is required to register as a lobbyist under Chapter 305,
26 Government Code, because of the person's activities for
27 compensation related to the operation of the department or the
28 office. (V.T.I.C. Art. 1.35A, Sec. 4(a).)

29 Source Law

30 Sec. 4. (a) A person may not serve as the
31 public counsel or act as the general counsel for the
32 office of public insurance counsel if the person is
33 required to register as a lobbyist under Chapter 305,
34 Government Code, because of the person's activities
35 for compensation related to the operation of the
36 department or the office of public insurance counsel.

37 Revised Law

38 Sec. 501.055. GROUNDS FOR REMOVAL. (a) It is a ground for
39 removal from office if the public counsel:

40 (1) does not have at the time of appointment or
41 maintain during service as public counsel the qualifications
42 required by Section 501.052;

43 (2) violates a prohibition established by Section
44 501.053, 501.054, 501.056, or 501.102; or

45 (3) cannot, because of illness or disability,

1 discharge the public counsel's duties for a substantial part of the
2 public counsel's term.

3 (b) The validity of an action of the office is not affected
4 by the fact that the action is taken when a ground for removal of the
5 public counsel exists. (V.T.I.C. Art. 1.35A, Secs. 2(f), (g).)

6 Source Law

7 (f) It is a ground for removal from office if the
8 public counsel:

9 (1) does not have at the time of
10 appointment the qualifications required by Subsection
11 (b) of this section;

12 (2) does not maintain during service as
13 public counsel the qualifications required by
14 Subsection (b) of this section;

15 (3) violates a prohibition established by
16 Subsection (c) of this section or Section 4 of this
17 article; or

18 (4) cannot discharge the public counsel's
19 duties for a substantial part of the term for which the
20 public counsel is appointed because of illness or
21 disability.

22 (g) The validity of an action of the office of
23 public insurance counsel is not affected by the fact
24 that it is taken when a ground for removal of the
25 public counsel exists.

26 Revised Law

27 Sec. 501.056. PROHIBITED REPRESENTATION OR EMPLOYMENT. A
28 former public counsel may not represent any person or receive
29 compensation for services rendered on behalf of any person
30 regarding a case pending before the commissioner or department
31 before the second anniversary of the date the person ceases to serve
32 as public counsel. (V.T.I.C. Art. 1.35A, Sec. 4(b).)

33 Source Law

34 (b) A person serving as the public counsel may
35 not, for a period of two years after the date the
36 person ceases to be public counsel, represent any
37 person in a proceeding before the board or receive
38 compensation for services rendered on behalf of any
39 person regarding a case pending before the rate board,
40 commissioner, or department.

41 Revisor's Note

42 Section 4(b), V.T.I.C. Article 1.35A, refers to
43 proceedings "before the board," meaning the State
44 Board of Insurance, and cases pending before "the rate
45 board, commissioner, or department." Chapter 685,
46 Acts of the 73rd Legislature, Regular Session, 1993,

1 abolished the State Board of Insurance and transferred
2 its functions to the commissioner of insurance and the
3 Texas Department of Insurance. For that reason, the
4 reference to the board has been changed to
5 "department" and "commissioner." The revised law
6 omits the reference to "rate board" because there is no
7 rate board within the Texas Department of Insurance.

8 [Sections 501.057-501.100 reserved for expansion]

9 SUBCHAPTER C. PERSONNEL

10 Revised Law

11 Sec. 501.101. OFFICE PERSONNEL. (a) The public counsel
12 shall employ professional, technical, and other employees
13 necessary to implement this chapter.

14 (b) Compensation for an employee shall be set under the
15 General Appropriations Act as provided by the legislature.
16 (V.T.I.C. Art. 1.35A, Sec. 3(a) (part).)

17 Source Law

18 Sec. 3. (a) The public counsel, . . . shall be
19 charged with the responsibility of . . . employing all
20 necessary professional, technical, and other
21 employees to carry out the provisions of this article,
22 The compensation for employees of the office
23 of public insurance counsel shall be fixed by the
24 legislature as provided by the General Appropriations
25 Act.

26 Revised Law

27 Sec. 501.102. TRADE ASSOCIATIONS. (a) In this section,
28 "trade association" means a nonprofit, cooperative, and
29 voluntarily joined association of business or professional
30 competitors designed to assist its members and its industry or
31 profession in dealing with mutual business or professional problems
32 and in promoting their common interest.

33 (b) A person may not serve as public counsel or be an
34 employee of the office who is exempt from the state's position
35 classification plan or is compensated at or above the amount
36 prescribed by the General Appropriations Act for step 1, salary
37 group A17, of the position classification salary schedule if the

1 person is:

2 (1) an officer, employee, or paid consultant of a
3 trade association in the field of insurance; or

4 (2) the spouse of an officer, manager, or paid
5 consultant of a trade association in the field of insurance.
6 (V.T.I.C. Art. 1.35A, Secs. 4(c), (d), (e).)

7 Source Law

8 (c) An officer, employee, or paid consultant of
9 a trade association in the field of insurance may not
10 serve as the public counsel or be an employee of the
11 office of public insurance counsel who is exempt from
12 the state's position classification plan or is
13 compensated at or above the amount prescribed by the
14 General Appropriations Act for step 1, salary group
15 17, of the position classification salary schedule.

16 (d) A person who is the spouse of an officer,
17 manager, or paid consultant of a trade association in
18 the field of insurance may not serve as the public
19 counsel and may not be an office of public insurance
20 counsel employee who is exempt from the state's
21 position classification plan or is compensated at or
22 above the amount prescribed by the General
23 Appropriations Act for step 1, salary group 17, of the
24 position classification salary schedule.

25 (e) For purposes of this section, a trade
26 association is a nonprofit, cooperative, and
27 voluntarily joined association of business or
28 professional competitors designed to assist its
29 members and its industry or profession in dealing with
30 mutual business or professional problems and in
31 promoting their common interest.

32 Revisor's Note

33 Sections 4(c) and (d), V.T.I.C. Article 1.35A,
34 refer to employment in a position "compensated at or
35 above the amount prescribed by the General
36 Appropriations Act for step 1, salary group 17, of the
37 position classification salary schedule." Under the
38 General Appropriations Act for the 1996-1997 and
39 earlier state bienniums, there was a single position
40 classification salary schedule. Under Article IX of
41 the General Appropriations Act for the 2002-2003 state
42 fiscal biennium (Chapter 1515, Acts of the 77th
43 Legislature, Regular Session, 2001), there are three
44 position classification salary schedules. "Salary
45 group 17" under the former schedule corresponds to

1 "salary group A17" under the current schedule. The
2 revised law is drafted accordingly.

3 Revised Law

4 Sec. 501.103. CAREER LADDER PROGRAM; PERFORMANCE
5 EVALUATIONS. (a) The public counsel or the public counsel's
6 designee shall develop an intra-agency career ladder program. The
7 program must require intra-agency posting of all nonentry level
8 positions concurrently with any public posting.

9 (b) The public counsel or the public counsel's designee
10 shall develop a system of annual performance evaluations. All
11 merit pay for office employees must be based on the system
12 established under this subsection. (V.T.I.C. Art. 1.35A, Secs.
13 3(g), (h).)

14 Source Law

15 (g) The public counsel or the public counsel's
16 designee shall develop an intra-agency career ladder
17 program. The program shall require intra-agency
18 posting of all nonentry level positions concurrently
19 with any public posting.

20 (h) The public counsel or the public counsel's
21 designee shall develop a system of annual performance
22 evaluations. All merit pay for office of public
23 insurance counsel employees must be based on the
24 system established under this subsection.

25 Revised Law

26 Sec. 501.104. EQUAL EMPLOYMENT OPPORTUNITY POLICY;
27 REPORT. (a) The public counsel or the public counsel's designee
28 shall prepare and maintain a written policy statement to ensure
29 implementation of an equal employment opportunity program under
30 which all personnel transactions are made without regard to race,
31 color, disability, sex, religion, age, or national origin. The
32 policy statement must include:

33 (1) personnel policies, including policies relating
34 to recruitment, evaluation, selection, appointment, training, and
35 promotion of personnel that are in compliance with the requirements
36 of Chapter 21, Labor Code;

37 (2) a comprehensive analysis of the office workforce
38 that meets federal and state guidelines;

1 (3) procedures by which a determination can be made
2 about areas of significant underuse in the office workforce of all
3 persons for whom federal or state guidelines encourage a more
4 equitable balance; and

5 (4) reasonable methods to appropriately address those
6 areas of significant underuse.

7 (b) A policy statement prepared under Subsection (a) must:

8 (1) cover an annual period;

9 (2) be updated at least annually;

10 (3) be reviewed by the Commission on Human Rights for
11 compliance with Subsection (a)(1); and

12 (4) be filed with the governor.

13 (c) The governor shall deliver a biennial report to the
14 legislature based on the information received under Subsection (b).
15 The report may be made separately or as a part of other biennial
16 reports to the legislature. (V.T.I.C. Art. 1.35A, Secs. 3(d), (e),
17 (f).)

18 Source Law

19 (d) The public counsel or the public counsel's
20 designee shall prepare and maintain a written policy
21 statement to ensure implementation of a program of
22 equal employment opportunity under which all personnel
23 transactions are made without regard to race, color,
24 disability, sex, religion, age, or national origin.
25 The policy statement must include:

26 (1) personnel policies, including
27 policies relating to recruitment, evaluation,
28 selection, appointment, training, and promotion of
29 personnel that are in compliance with the Texas
30 Commission on Human Rights Act (Article 5221k,
31 Vernon's Texas Civil Statutes) and its subsequent
32 amendments;

33 (2) a comprehensive analysis of the office
34 of public insurance counsel work force that meets
35 federal and state guidelines;

36 (3) procedures by which a determination
37 can be made of significant underuse in the office of
38 public insurance counsel work force of all persons for
39 whom federal or state guidelines encourage a more
40 equitable balance; and

41 (4) reasonable methods to appropriately
42 address those areas of significant underuse.

43 (e) A policy statement prepared under
44 Subsection (d) of this section must cover an annual
45 period, be updated at least annually and reviewed by
46 the Commission on Human Rights for compliance with
47 Subsection (d)(1) of this section, and be filed with
48 the governor's office.

49 (f) The governor's office shall deliver a

1 biennial report to the legislature based on the
2 information received under Subsection (e) of this
3 section. The report may be made separately or as a
4 part of other biennial reports made to the
5 legislature.

6 Revisor's Note

7 Section 3(d)(1), V.T.I.C. Article 1.35A, refers
8 to the Texas Commission on Human Rights Act (Article
9 5221k, Vernon's Texas Civil Statutes) and its
10 subsequent amendments. The relevant portions of that
11 statute were codified in 1993 as Chapter 21, Labor
12 Code, and the revised law is drafted accordingly. The
13 revised law omits the reference to "subsequent
14 amendments" because under Section 311.027, Government
15 Code (Code Construction Act), unless expressly
16 provided otherwise, a reference to a statute applies
17 to all reenactments, revisions, or amendments of the
18 statute.

19 Revised Law

20 Sec. 501.105. QUALIFICATIONS AND STANDARDS OF CONDUCT. The
21 office shall provide to the public counsel and office employees, as
22 often as necessary, information regarding their:

23 (1) qualifications for office or employment under this
24 chapter; and

25 (2) responsibilities under applicable laws relating
26 to standards of conduct for state officers or employees. (V.T.I.C.
27 Art. 1.35A, Sec. 3(i).)

28 Source Law

29 (i) The office of public insurance counsel shall
30 provide to its public counsel and employees, as often
31 as necessary, information regarding their
32 qualification for office or employment under this
33 article and their responsibilities under applicable
34 laws relating to standards of conduct for state
35 officers or employees.

36 [Sections 501.106-501.150 reserved for expansion]

37 SUBCHAPTER D. POWERS AND DUTIES

38 Revised Law

39 Sec. 501.151. POWERS AND DUTIES OF OFFICE. The office:

1 (1) may assess the impact of insurance rates, rules,
2 and forms on insurance consumers in this state; and

3 (2) shall advocate in the office's own name positions
4 determined by the public counsel to be most advantageous to a
5 substantial number of insurance consumers. (V.T.I.C. Art. 1.35A,
6 Sec. 5(a).)

7 Source Law

8 Sec. 5. (a) The office of public insurance
9 counsel may assess the impact of insurance rates,
10 rules, and forms on insurance consumers in Texas and,
11 in its own name, shall act as an advocate of positions
12 that are most advantageous to a substantial number of
13 insurance consumers as determined by the public
14 counsel for the office.

15 Revised Law

16 Sec. 501.152. ADMINISTRATION OF OFFICE. The public
17 counsel shall administer and enforce this chapter, including
18 preparing and submitting to the legislature a budget for the office
19 and approving expenditures for professional services, travel, per
20 diem, and other actual and necessary expenses incurred in
21 administering the office. (V.T.I.C. Art. 1.35A, Sec. 3(a) (part).)

22 Source Law

23 Sec. 3. (a) The public counsel, . . . shall be
24 charged with the responsibility of administering,
25 enforcing, and carrying out the provisions of this
26 article, including preparation and submission to the
27 legislature of a budget for the office, . . . approval
28 of expenditures for professional services, travel, per
29 diem, and other actual and necessary expenses incurred
30 in administering the office. . . .

31 Revisor's Note

32 Section 3(a), V.T.I.C. Article 1.35A, charges the
33 public counsel with "administering, enforcing, and
34 carrying out" this chapter. The revised law omits the
35 reference to "carrying out" because it is included in
36 the meaning of "administer" and "enforce."

37 Revised Law

38 Sec. 501.153. AUTHORITY TO APPEAR, INTERVENE, OR INITIATE.
39 The public counsel:

40 (1) may appear or intervene, as a party or otherwise,

1 as a matter of right before the commissioner or department on behalf
2 of insurance consumers, as a class, in matters involving:

3 (A) rates, rules, and forms affecting:

4 (i) property and casualty insurance;

5 (ii) title insurance;

6 (iii) credit life insurance;

7 (iv) credit accident and health insurance;

8 or

9 (v) any other line of insurance for which
10 the commissioner or department promulgates, sets, adopts, or
11 approves rates, rules, or forms;

12 (B) rules affecting life, health, or accident
13 insurance; or

14 (C) withdrawal of approval of policy forms:

15 (i) in proceedings initiated by the
16 department under Sections 1701.055 and 1701.057; or

17 (ii) if the public counsel presents
18 persuasive evidence to the department that the forms do not comply
19 with this code, a rule adopted under this code, or any other law;

20 (2) may initiate or intervene as a matter of right or
21 otherwise appear in a judicial proceeding involving or arising from
22 an action taken by an administrative agency in a proceeding in which
23 the public counsel previously appeared under the authority granted
24 by this chapter;

25 (3) may appear or intervene, as a party or otherwise,
26 as a matter of right on behalf of insurance consumers as a class in
27 any proceeding in which the public counsel determines that
28 insurance consumers are in need of representation, except that the
29 public counsel may not intervene in an enforcement or *parens*
30 *patriae* proceeding brought by the attorney general; and

31 (4) may appear or intervene before the commissioner or
32 department as a party or otherwise on behalf of small commercial
33 insurance consumers, as a class, in a matter involving rates,
34 rules, or forms affecting commercial insurance consumers, as a

1 class, in any proceeding in which the public counsel determines
2 that small commercial consumers are in need of representation.
3 (V.T.I.C. Art. 1.35A, Sec. 5(b) (part).)

4 Source Law

5 (b) The public counsel:

6 (1) may appear or intervene as a matter of
7 right before the commissioner or department as a party
8 or otherwise on behalf of insurance consumers as a
9 class in:

10 (A) matters involving rates, rules,
11 and forms affecting property and casualty insurance;

12 (B) matters involving rates, rules,
13 and forms affecting title insurance;

14 (C) matters involving rules
15 affecting life, health, and accident insurance;

16 (D) matters involving rates, rules,
17 and forms affecting credit life, and credit accident
18 and health insurance;

19 (E) matters involving rates, rules,
20 and forms affecting all other lines of insurance for
21 which the commissioner or department promulgates,
22 sets, or approves rates, rules, and/or forms; and

23 (F) matters involving withdrawal of
24 approval of policy forms in proceedings initiated by
25 the department under Articles 3.42(f) and 3.42(g) of
26 this code or if the public counsel presents persuasive
27 evidence to the department that such forms do not
28 comply with such articles of this code or any valid
29 rule relating thereto duly adopted by the commissioner
30 or are otherwise contrary to law;

31 (2) may initiate or intervene as a matter
32 of right or otherwise appear in a judicial proceeding
33 involving or arising out of any action taken by an
34 administrative agency in a proceeding in which the
35 public counsel previously appeared under the authority
36 granted by this article;

37
38 (6) may appear or intervene as a matter of
39 right as a party or otherwise on behalf of insurance
40 consumers as a class in all proceedings in which the
41 public counsel determines that insurance consumers
42 need representation, except that the public counsel
43 may not intervene in any enforcement or parens patriae
44 proceeding brought by the attorney general;

45 (7) may appear or intervene before the
46 commissioner or department as a party or otherwise on
47 behalf of small commercial insurance consumers, as a
48 class, in matters involving rates, rules, and forms
49 affecting commercial insurance consumers, as a class,
50 in all proceedings where it is deemed by the counsel
51 that small commercial consumers are in need of
52 representation; and

53 . . .

54 Revisor's Note

55 (1) Section 5(b)(1)(E), V.T.I.C. Article 1.35A,
56 refers to rates, rules, and forms promulgated, set, or
57 approved by the department or commissioner. The
58 revised law adds a reference to "adopts" to be

1 consistent with terminology used in this code.

2 (2) Section 5(b)(1)(F), V.T.I.C. Article 1.35A,
3 refers to "proceedings initiated by the department
4 under Articles 3.42(f) and 3.42(g) of this code." The
5 revised law substitutes references to Articles
6 3.42(i), 3.42(k), and 3.42(m), revised in this code as
7 Sections 1701.055 and 1701.057, for "3.42(f) and
8 3.42(g)" because Section 1, Chapter 176, Acts of the
9 74th Legislature, Regular Session, 1995, redesignated
10 Article 3.42(f) as 3.42(i) and Article 3.42(g) as
11 Articles 3.42(k) and (m).

12 (3) Section 5(b)(1)(F), V.T.I.C. Article 1.35A,
13 refers to a "valid rule." The revised law omits
14 "valid" as unnecessary because the word does not add to
15 the clear meaning of the law. A rule that is not valid
16 is no longer a rule.

17 Revised Law

18 Sec. 501.154. ACCESS TO INFORMATION. The public counsel:

19 (1) is entitled to the same access as a party, other
20 than department staff, to department records available in a
21 proceeding before the commissioner or department under the
22 authority granted to the public counsel by this chapter; and

23 (2) is entitled to obtain discovery under Chapter
24 2001, Government Code, of any nonprivileged matter that is relevant
25 to the subject matter involved in a proceeding or submission before
26 the commissioner or department as authorized by this chapter.
27 (V.T.I.C. Art. 1.35A, Sec. 5(b) (part).)

28 Source Law

29 (b) The public counsel:

30 . . .
31 (3) is entitled to access to any records of
32 the department that are available to any party other
33 than the department staff in a proceeding before the
34 commissioner or department under the authority granted
35 public counsel by this article;

36 (4) is entitled to obtain discovery under
37 the Administrative Procedure and Texas Register Act
38 (Article 6252-13a, Vernon's Texas Civil Statutes) of
39 any nonprivileged matter that is relevant to the

1 subject matter involved in a proceeding or submission
2 before the commissioner or department as authorized by
3 this article;

4 . . .

5 Revisor's Note

6 Section 5(b)(4), V.T.I.C. Article 1.35A, refers
7 to the Administrative Procedure and Texas Register Act
8 (Article 6252-13a, Vernon's Texas Civil Statutes).
9 Article 6252-13a was codified in 1993 as Chapter 2001,
10 Government Code. The revised law is drafted
11 accordingly.

12 Revised Law

13 Sec. 501.155. RECOMMENDATION OF LEGISLATION. The public
14 counsel may recommend legislation to the legislature that the
15 public counsel determines would positively affect the interests of
16 insurance consumers. (V.T.I.C. Art. 1.35A, Sec. 5(b) (part).)

17 Source Law

18 (b) The public counsel:

19 . . .

20 (5) may recommend legislation to the
21 legislature that, in the judgment of the public
22 counsel, would affect positively the interests of
23 insurance consumers;

24 . . .

25 Revised Law

26 Sec. 501.156. CONSUMER BILL OF RIGHTS. The public counsel
27 shall submit to the department for adoption a consumer bill of
28 rights appropriate to each personal line of insurance regulated by
29 the department to be distributed on issuance of a policy by an
30 insurer to each policyholder under department rules. (V.T.I.C.
31 Art. 1.35A, Sec. 5(b) (part).)

32 Source Law

33 (b) The public counsel:

34 . . .

35 (8) shall submit to the department for
36 adoption a consumer bill of rights appropriate to each
37 personal line of insurance regulated by the department
38 to be distributed upon the issuance of a policy by
39 insurers to each policyholder under rules adopted by
40 the department.

41 Revised Law

42 Sec. 501.157. PROHIBITED INTERVENTIONS OR APPEARANCES. The

1 public counsel may not intervene or appear in:

2 (1) any proceeding or hearing before the commissioner
3 or department, or any other proceeding, that relates to approval or
4 consideration of an individual charter, license, certificate of
5 authority, acquisition, merger, or examination; or

6 (2) any proceeding concerning the solvency of an
7 individual insurer, a financial issue, a policy form, advertising,
8 or another regulatory issue affecting an individual insurer or
9 agent. (V.T.I.C. Art. 1.35A, Sec. 5(c) (part).)

10 Source Law

11 (c) The public counsel may not intervene or
12 appear in any proceedings or hearings before the
13 commissioner or department, or other proceedings, that
14 relate to approval or consideration of individual
15 charters, licenses, acquisitions, mergers,
16 examinations, proceedings concerning the solvency of
17 individual insurers, financial issues, policy forms,
18 advertising, or other regulatory issues affecting
19 individual insurers or agents. . . .

20 Revisor's Note

21 Section 5(c), V.T.I.C. Article 1.35A, refers to
22 proceedings or hearings related to the approval or
23 consideration of individual charters or licenses. The
24 revised law adds the term "certificate of authority"
25 because under this code an insurer is issued a
26 certificate of authority by the Texas Department of
27 Insurance to authorize the insurer to engage in
28 business in this state.

29 Revised Law

30 Sec. 501.158. CONFIDENTIALITY REQUIREMENTS.
31 Confidentiality requirements applicable to examination reports
32 under Article 1.18 and to the commissioner under Section 3A,
33 Article 21.28-A, apply to the public counsel. (V.T.I.C.
34 Art. 1.35A, Sec. 5(c) (part).)

35 Source Law

36 (c) . . . The confidentiality requirements
37 applicable to examination reports under Article 1.18
38 of this code and to the commissioner under Section 3A,
39 Article 21.28, of this code shall apply to the public
40 counsel.

1 Revisor's Note

2 Section 5(c), V.T.I.C. Article 1.35A, refers to
3 confidentiality requirements under Section 3A,
4 Article 21.28. The revised law corrects the reference
5 by substituting "Article 21.28-A" for "Article 21.28."
6 Section 3A, Article 21.28, does not in any manner
7 address confidentiality requirements, while Section
8 3A, Article 21.28-A does address such requirements and
9 in context is clearly the correct reference.

10 [Sections 501.159-501.200 reserved for expansion]

11 SUBCHAPTER E. ASSESSMENTS

12 Revised Law

13 Sec. 501.201. OFFICE EXPENSES. Expenses of the office
14 shall be paid from the assessments collected under this subchapter.
15 (V.T.I.C. Art. 1.35A, Sec. 3(a) (part).)

16 Source Law

17 Sec. 3. (a) . . . Expenses for the office
18 shall be paid from the assessment imposed in Article
19 1.35B of this chapter. . . .

20 Revised Law

21 Sec. 501.202. ASSESSMENT. To defray the costs of operating
22 the office, the comptroller shall collect assessments under this
23 subchapter annually in connection with the collection of other
24 taxes imposed on an insurer. (V.T.I.C. Art. 1.35B, Sec. (a)
25 (part).)

26 Source Law

27 Art. 1.35B. (a) To defray the costs of creating,
28 administering, and operating the office of public
29 insurance counsel, the comptroller shall collect the
30 following assessments annually in connection with the
31 collection of other taxes imposed on insurers:
32 . . .

33 Revisor's Note

34 Section (a), V.T.I.C. Article 1.35B, refers to
35 the comptroller collecting assessments in order "[t]o
36 defray the costs of creating, administering, and
37 operating the office of public insurance counsel."

1 The revised law omits the reference to creating the
2 independent office of public insurance counsel as
3 unnecessary because that provision is executed. The
4 revised law omits the reference to "administering"
5 because "administering" is included within the meaning
6 of "operating."

7 Revised Law

8 Sec. 501.203. ASSESSMENT ON PROPERTY AND CASUALTY
9 INSURERS. Each property and casualty insurer authorized to engage
10 in business in this state shall pay an annual assessment of 5.7
11 cents for each property and casualty insurance policy in force in
12 this state at the end of the year. (V.T.I.C. Art. 1.35B, Sec. (a)
13 (part).)

14 Source Law

15 (a) . . .
16 (1) each property and casualty insurer
17 authorized to do business in this state shall pay an
18 annual assessment of 5.7 cents for each policy of
19 property and casualty insurance in force at year end in
20 this state;
21 . . .

22 Revised Law

23 Sec. 501.204. ASSESSMENT ON LIFE, HEALTH, AND ACCIDENT
24 INSURERS AND RELATED ENTITIES. (a) This section applies to each
25 insurer authorized to engage in business in this state under:

- 26 (1) Chapter 25;
- 27 (2) Chapter 841;
- 28 (3) Chapter 842;
- 29 (4) Chapter 843;
- 30 (5) Chapter 882;
- 31 (6) Chapter 884;
- 32 (7) Chapter 885;
- 33 (8) Chapter 887;
- 34 (9) Chapter 888;
- 35 (10) Chapter 961;
- 36 (11) Chapter 982;
- 37 (12) Subchapter B, Chapter 1103;

- 1 (13) Subchapter A, Chapter 1104;
 2 (14) Chapter 1201, or a provision listed in Section
 3 1201.005;
 4 (15) Chapter 1551;
 5 (16) Chapter 1578; or
 6 (17) Chapter 1601.

7 (b) Each insurer subject to this section shall pay an annual
 8 assessment of 5.7 cents for each individual policy, and for each
 9 certificate of insurance evidencing coverage under a group policy,
 10 of life, health, or accident insurance that is written for delivery
 11 and placed in force in this state during each calendar year and for
 12 which the initial premium is paid in full. (V.T.I.C. Art. 1.35B,
 13 Sec. (a) (part).)

14 Source Law

- 15 (a)
 16 (2) each insurer shall pay an annual
 17 assessment of 5.7 cents for each individual policy,
 18 and for each certificate of insurance evidencing
 19 coverage under a group policy, of life, health, or
 20 accident insurance written for delivery and placed in
 21 force with the initial premium thereon paid in full in
 22 this state during each calendar year if the insurer is
 23 authorized to do business in this state under:
 24 (A) Chapter 3, 10, 11, 14, 20, 22, 23,
 25 or 25 of this code;
 26 (B) Chapter 113, Acts of the 53rd
 27 Legislature, Regular Session, 1953 (Article 3.49-1,
 28 Vernon's Texas Insurance Code);
 29 (C) Section 1, Chapter 417, Acts of
 30 the 56th Legislature, Regular Session, 1959 (Article
 31 3.49-2, Vernon's Texas Insurance Code);
 32 (D) the Texas Employees Uniform Group
 33 Insurance Benefits Act (Article 3.50-2, Vernon's Texas
 34 Insurance Code);
 35 (E) the Texas State College and
 36 University Employees Uniform Insurance Benefits Act
 37 (Article 3.50-3, Vernon's Texas Insurance Code);
 38 (F) Section 1, Chapter 123, Acts of
 39 the 60th Legislature, Regular Session, 1967 (Article
 40 3.51-3, Vernon's Texas Insurance Code);
 41
 42 (H) Sections 1 to 3A and 4 to 13,
 43 Chapter 397, Acts of the 54th Legislature, Regular
 44 Session, 1955 (Articles 3.70-1 to 3.70-3A and 3.70-4
 45 to 3.70-11, Vernon's Texas Insurance Code); or
 46 (I) the Texas Health Maintenance
 47 Organization Act (Chapter 20A, Vernon's Texas
 48 Insurance Code); and
 49

50 Revisor's Note

- 51 (1) Section (a)(2)(A), V.T.I.C. Article 1.35B,

1 requires the comptroller to collect an assessment from
2 insurers authorized to engage in business in this
3 state under Chapter 3 of the Insurance Code. The
4 revised law substitutes "Chapter 841" and "Chapter
5 982" for "Chapter 3" because the relevant provisions
6 of Chapter 3 relating to authorizing an insurer to
7 engage in business in this state have been revised in
8 Chapter 841 and Chapter 982.

9 (2) Section (a)(2)(G), V.T.I.C. Article 1.35B,
10 requires the comptroller to collect an assessment from
11 an insurer authorized to engage in business under
12 Section 1, Chapter 387, Acts of the 55th Legislature,
13 Regular Session, 1957. The revised law omits the
14 reference because that section was repealed by Section
15 12.01(3), Chapter 242, Acts of the 72nd Legislature,
16 Regular Session, 1991. The omitted law reads:

17 (2)
18 (G) Section 1, Chapter
19 387, Acts of the 55th Legislature, Regular
20 Session, 1957 (Article 3.62-1, Vernon's
21 Texas Insurance Code);
22

23 Revised Law

24 Sec. 501.205. ASSESSMENT ON TITLE INSURANCE COMPANIES.
25 Each title insurance company authorized to engage in business in
26 this state shall pay an annual assessment of 5.7 cents for each
27 owner and mortgage policy that is written for delivery in this state
28 during each calendar year and for which the full basic premium is
29 charged. (V.T.I.C. Art. 1.35B, Sec. (a) (part).)

30 Source Law

31 (a)
32 (3) each title insurance company
33 authorized to do business in this state shall pay an
34 annual assessment of 5.7 cents for each owner policy
35 and mortgage policy of title insurance written for
36 delivery in this state during each calendar year and
37 for which the full basic premium is charged.

38 Revisor's Note
39 (End of Subchapter)

40 Sections (b), (c), and (d), V.T.I.C. Article

1 1.35B, create a special account in the state treasury
2 for the office of public insurance counsel, require
3 the comptroller to adopt rules regarding payments to
4 the account, and authorize all amounts in the account
5 to be used for certain purposes. In 1991, the
6 legislature enacted Section 403.094, Government Code,
7 now repealed, under which many funds were merged into
8 the general revenue fund in 1993 and many accounts were
9 abolished on September 1, 1995. The revised law omits
10 Sections (b), (c), and (d), Article 1.35B, because the
11 account ceased to exist as a result of actions taken
12 under the former Government Code provision. The
13 omitted law reads:

14 (b) The office of public insurance
15 counsel account is created in the State
16 Treasury, and all assessments collected
17 under this article must be deposited in the
18 State Treasury to the credit of that account
19 as provided by rules of the comptroller of
20 public accounts.

21 (c) The comptroller of public
22 accounts shall adopt necessary rules to
23 provide for the payment to the office of
24 public insurance counsel account of
25 assessments collected from insurers under
26 this article.

27 (d) Money deposited in the office of
28 public insurance counsel account may be
29 appropriated for the purpose of paying the
30 costs of creating, administering, and
31 operating the office.

32 [Sections 501.206-501.250 reserved for expansion]

33 SUBCHAPTER F. DUTIES RELATING TO HEALTH

34 MAINTENANCE ORGANIZATIONS

35 Revised Law

36 Sec. 501.251. COMPARISON OF HEALTH MAINTENANCE
37 ORGANIZATIONS. (a) The office shall develop and implement a
38 system to compare and evaluate, on an objective basis, the quality
39 of care provided by and the performance of health maintenance
40 organizations established under Chapter 843.

41 (b) In developing the system, the office may use information
42 or data from a person, agency, organization, or governmental unit

1 that the office considers reliable. (V.T.I.C. Art. 1.35A, Sec.
2 5(e) (part).)

3 Source Law

4 (e) The office of public insurance counsel shall
5 develop and implement a system to compare and
6 evaluate, on an objective basis, the quality of care
7 provided by and the performance of health maintenance
8 organizations that are established under the Texas
9 Health Maintenance Organization Act (Chapter 20A,
10 Vernon's Texas Insurance Code).

11 (1) In developing the system under this
12 subsection, the office of public insurance counsel may
13 use information or data from any person, agency,
14 organization, or governmental unit that the office
15 deems reliable. . . .

16 Revised Law

17 Sec. 501.252. ANNUAL CONSUMER REPORT CARDS. (a) The
18 office shall develop and issue annual consumer report cards that
19 identify and compare, on an objective basis, health maintenance
20 organizations in this state. The consumer report cards may be based
21 on information or data from any person, agency, organization, or
22 governmental unit that the office considers reliable.

23 (b) The office may not endorse or recommend a specific
24 health maintenance organization or plan, or subjectively rate or
25 rank health maintenance organizations or plans, other than through
26 comparison and evaluation of objective criteria.

27 (c) The office shall provide a copy of any consumer report
28 card on request on payment of a reasonable fee. (V.T.I.C.
29 Art. 1.35A, Secs. 5(e)(2), (10), (11).)

30 Source Law

31 (2) The office of public insurance counsel
32 shall develop and issue annually consumer report cards
33 that identify and compare, on an objective basis,
34 health maintenance organizations in this state. The
35 consumer report card may be based on information or
36 data from any person, agency, organization, or
37 governmental unit that the office deems reliable.

38 (10) The office of public insurance
39 counsel may not endorse or recommend a specific health
40 maintenance organization or plan, or subjectively rate
41 or rank such organizations or plans, other than
42 through comparison and evaluation of objective
43 criteria.

44 (11) The office of public insurance
45 counsel shall provide a copy of the consumer report to
46 any person on request on payment of a reasonable fee.

1 Revised Law

2 Sec. 501.253. ACCESS TO INFORMATION. (a) The office is
3 entitled to information that is confidential under a law of this
4 state, including Section 843.006 of this code, Chapter 108, Health
5 and Safety Code, and Chapter 552, Government Code.

6 (b) The department and the Texas Health Care Information
7 Council shall provide any information or data as requested by the
8 office in furtherance of the duties under this subchapter.

9 (c) The office shall use information collected or received
10 under this subchapter for the benefit of the public. (V.T.I.C.
11 Art. 1.35A, Secs. 5(e)(3), (4) (part), (5).)

12 Source Law

13 (3) The department and the health care
14 information council shall provide information or data
15 as requested by the office of public insurance counsel
16 in furtherance of these duties.

17 (4) The office of public insurance counsel
18 shall use the information collected or received under
19 this subsection for the benefit of the public. . . .

20 (5) The office of public insurance counsel
21 is entitled to information that is confidential under
22 any law of this state, including Section 27, Texas
23 Health Maintenance Organization Act (Article 20A.27,
24 Vernon's Texas Insurance Code), Chapter 108, Health
25 and Safety Code, and Chapter 552, Government Code.

26 Revisor's Note

27 Section 5(e)(3), V.T.I.C. Article 1.35A, refers
28 to the health care information council. The revised
29 law substitutes "Texas Health Care Information
30 Council" for "the health care information council"
31 because under Chapter 108, Health and Safety Code,
32 that is the official name of the agency.

33 Revised Law

34 Sec. 501.254. CONFIDENTIALITY AND USE OF INFORMATION. (a)
35 Except as provided by this section, information collected under
36 this subchapter is subject to Chapter 552, Government Code, and the
37 office shall make determinations on requests for information in
38 favor of access.

39 (b) The office may not make public any confidential
40 information provided to the office under this subchapter but may

1 disclose a summary of the information that does not directly or
2 indirectly identify the health maintenance organization that is the
3 subject of the information. The office may not release, and a
4 person or entity may not gain access to, any information that:

5 (1) could reasonably be expected to reveal the
6 identity of a patient or physician;

7 (2) reveals the zip code of a patient's primary
8 residence;

9 (3) discloses a provider discount or a differential
10 between a payment and a billed charge; or

11 (4) relates to an actual payment made by a payer to an
12 identified provider.

13 (c) Information collected or used by the office under this
14 subchapter is subject to the confidentiality provisions and
15 criminal penalties of:

16 (1) Section 81.103, Health and Safety Code;

17 (2) Section 311.037, Health and Safety Code; and

18 (3) Chapter 159, Occupations Code.

19 (d) Information on patients and physicians that is in the
20 possession of the office and any compilation, report, or analysis
21 produced from the information that identifies patients and
22 physicians is not:

23 (1) subject to discovery, subpoena, or other means of
24 legal compulsion for release to any person or entity; or

25 (2) admissible in any civil, administrative, or
26 criminal proceeding.

27 (e) Notwithstanding Subsection (b)(2), the office may use
28 zip code information to analyze information on a geographical
29 basis. (V.T.I.C. Art. 1.35A, Secs. 5(e)(4) (part), (6), (7), (8),
30 (9).)

31 Source Law

32 (4) . . . Except as provided by this
33 subsection, the information is subject to the open
34 records law, Chapter 552, Government Code, and the
35 office of public insurance counsel shall make
36 determinations on requests for information in favor of

1 access.

2 (6) The office of public insurance counsel
3 may not make public confidential information provided
4 to the office under this subsection but may disclose a
5 summary of the information that does not directly or
6 indirectly identify the health maintenance
7 organization that is the subject of the information.
8 The office of public insurance counsel may not
9 release, and a person or entity may not gain access to,
10 any information that:

11 (A) could reasonably be expected to
12 reveal the identity of a patient or physician or that
13 reveals the zip code of a patient's primary residence;

14 (B) discloses provider discounts or
15 differentials between payments and billed charges; or

16 (C) relates to actual payments to an
17 identified provider made by a payer.

18 (7) Information collected or used by the
19 office of public insurance counsel under this
20 subsection is subject to the confidentiality
21 provisions and criminal penalties of:

22 (A) Section 81.103, Health and Safety
23 Code;

24 (B) Section 311.037, Health and
25 Safety Code; and

26 (C) Section 5.08, Medical Practice
27 Act (Article 4495b, Vernon's Texas Civil Statutes).

28 (8) Information that is in the possession
29 of the office of public insurance counsel and that
30 relates to patients and physicians and any
31 compilation, report, or analysis produced from the
32 information that identifies patients and physicians is
33 not:

34 (A) subject to discovery, subpoena,
35 or other means of legal compulsion for release to any
36 person or entity; or

37 (B) admissible in any civil,
38 administrative, or criminal proceeding.

39 (9) Notwithstanding Subdivision (6)(A) of
40 this subsection, the office of public insurance
41 counsel may use zip code information to analyze
42 information on a geographic basis.

43 Revisor's Note

44 Section 5(e)(7), V.T.I.C. Article 1.35A, refers
45 to Section 5.08, Medical Practice Act (Article 4495b,
46 Vernon's Texas Civil Statutes). Section 5.08, Article
47 4495b, was codified in 1997 as Chapter 159,
48 Occupations Code. The revised law is drafted
49 accordingly.

50 [Chapters 502-520 reserved for expansion]

1 SUBTITLE B. CONSUMER SERVICE PROVISIONS

2 CHAPTER 521. CONSUMER INFORMATION AND COMPLAINTS

3 SUBCHAPTER A. PUBLIC INTEREST INFORMATION AND

4 COMPLAINT PROCEDURES

5 Sec. 521.001. PUBLIC INTEREST INFORMATION 176

6 Sec. 521.002. COMPLAINT RESOLUTION PROGRAM 177

7 Sec. 521.003. NOTIFICATION OF COMPLAINT STATUS 177

8 Sec. 521.004. RECORDS OF COMPLAINTS 177

9 Sec. 521.005. NOTICE TO ACCOMPANY POLICY. 178

10 [Sections 521.006-521.050 reserved for expansion]

11 SUBCHAPTER B. DEPARTMENT TOLL-FREE NUMBER FOR

12 INFORMATION AND COMPLAINTS

13 Sec. 521.051. DEPARTMENT TOLL-FREE NUMBER FOR

14 INFORMATION AND COMPLAINTS 178

15 Sec. 521.052. INFORMATION PROVIDED 179

16 Sec. 521.053. PUBLICITY REQUIREMENTS. 179

17 Sec. 521.054. RECORD OF INQUIRY OR COMPLAINT REQUIRED 180

18 Sec. 521.055. COMPLAINT NOTIFICATION SYSTEM. 180

19 Sec. 521.056. INFORMATION BULLETIN TO ACCOMPANY POLICY 181

20 [Sections 521.057-521.100 reserved for expansion]

21 SUBCHAPTER C. HEALTH MAINTENANCE ORGANIZATION OR

22 INSURER TOLL-FREE NUMBER FOR INFORMATION AND COMPLAINTS

23 Sec. 521.101. APPLICABILITY OF SUBCHAPTER 181

24 Sec. 521.102. HEALTH MAINTENANCE ORGANIZATION OR INSURER

25 TOLL-FREE NUMBER FOR INFORMATION AND

26 COMPLAINTS 182

27 Sec. 521.103. INFORMATION INCLUDED IN EVIDENCE OF COVERAGE

28 OR POLICY 183

29 CHAPTER 521. CONSUMER INFORMATION AND COMPLAINTS

30 SUBCHAPTER A. PUBLIC INTEREST INFORMATION AND COMPLAINT PROCEDURES

31 Revised Law

32 Sec. 521.001. PUBLIC INTEREST INFORMATION. (a) The

33 department shall prepare information of public interest describing

34 the department's functions and the procedures by which complaints

1 are filed with and resolved by the department.

2 (b) The department shall make the information available to
3 the public and appropriate state agencies. (V.T.I.C. Art. 1.37.)

4 Source Law

5 Art. 1.37. The department shall prepare
6 information of public interest describing the
7 functions of the department and describing the
8 department's procedures by which complaints are filed
9 with and resolved by the department. The department
10 shall make the information available to the public and
11 appropriate state agencies.

12 Revised Law

13 Sec. 521.002. COMPLAINT RESOLUTION PROGRAM. The department
14 shall establish a program to facilitate resolution of policyholder
15 complaints. (V.T.I.C. Art. 1.04B.)

16 Source Law

17 Art. 1.04B. The department shall establish a
18 program to facilitate resolution of policy holder
19 complaints.

20 Revised Law

21 Sec. 521.003. NOTIFICATION OF COMPLAINT STATUS. If a
22 written complaint is filed with the department, the department, at
23 least quarterly and until final disposition of the complaint, shall
24 notify each party to the complaint of the complaint's status unless
25 the notice would jeopardize an undercover investigation. (V.T.I.C.
26 Art. 1.10, Sec. 19.)

27 Source Law

28 19. Notice of Complaint Status. If a written
29 complaint is filed with the Department, the
30 Department, at least quarterly and until final
31 disposition of the complaint, shall notify the parties
32 to the complaint of the status of the complaint unless
33 the notice would jeopardize an undercover
34 investigation.

35 Revised Law

36 Sec. 521.004. RECORDS OF COMPLAINTS. The department shall
37 keep an information file about each complaint filed with the
38 department that concerns an activity regulated by the department or
39 the commissioner. (V.T.I.C. Art. 1.10, Sec. 18.)

40 Source Law

41 18. Complaint File. The Department shall keep an

1 information file about each complaint filed with the
2 Department concerning an activity that is regulated by
3 the Department or Commissioner.

4 Revised Law

5 Sec. 521.005. NOTICE TO ACCOMPANY POLICY. (a) Each
6 insurance policy delivered or issued for delivery in this state
7 shall include with the policy a brief written notice that includes:

8 (1) a suggested procedure to be followed by a
9 policyholder with a dispute concerning the policyholder's claim or
10 premium;

11 (2) the department's name and address; and

12 (3) the department's toll-free telephone number
13 maintained under Subchapter B.

14 (b) The commissioner shall adopt appropriate wording for
15 the notice. (V.T.I.C. Art. 1.35.)

16 Source Law

17 Art. 1.35. (a) Each insurance policy delivered
18 or issued for delivery in this state shall be
19 accompanied by a brief written notice of suggested
20 procedure to be followed by the policyholder in the
21 event of a dispute concerning a policyholder's claim or
22 premium.

23 (b) The notice must include the name and address
24 of the department and the toll-free telephone number
25 maintained under Article 1.35D of this code.

26 (c) The commissioner shall promulgate the
27 proper wording for the written notice.

28 [Sections 521.006-521.050 reserved for expansion]

29 SUBCHAPTER B. DEPARTMENT TOLL-FREE NUMBER FOR
30 INFORMATION AND COMPLAINTS

31 Revised Law

32 Sec. 521.051. DEPARTMENT TOLL-FREE NUMBER FOR INFORMATION
33 AND COMPLAINTS. The department shall maintain a toll-free telephone
34 number to:

35 (1) provide the information described by Section
36 521.052; and

37 (2) receive and aid in resolving complaints against
38 insurers. (V.T.I.C. Art. 1.35D, Sec. (a).)

39 Source Law

40 Art. 1.35D. (a) The department shall maintain a
41 toll-free telephone number to facilitate distribution

1 of information to be made available under Subsection
2 (b) of this article and to receive and to aid in
3 resolving complaints against insurers.

4 Revised Law

5 Sec. 521.052. INFORMATION PROVIDED. The department shall
6 provide to the public through the department's toll-free telephone
7 number only the following information:

8 (1) information collected or maintained by the
9 department relating to the number and disposition of complaints
10 received against an insurer that are justified, verified as
11 accurate, and documented as valid, expressed as a percentage of the
12 total number of insurance policies written by the insurer and in
13 force on December 31 of the preceding year;

14 (2) the rating of an insurer, if any, as published by a
15 nationally recognized rating organization;

16 (3) the kinds of coverage available to a consumer
17 through any insurer writing insurance in this state;

18 (4) an insurer's admitted assets-to-liabilities
19 ratio; and

20 (5) other appropriate information collected and
21 maintained by the department. (V.T.I.C. Art. 1.35D, Sec. (b).)

22 Source Law

23 (b) The department, through the toll-free
24 telephone number, shall provide only the following to
25 the public:

26 (1) information collected or maintained by
27 the department relating to the number of justified,
28 verified as accurate, and documented as valid
29 complaints received against a particular insurer, as a
30 percentage of the number of insurance policies written
31 by the insurer and in force on the preceding December
32 31, and the disposition of the complaints;

33 (2) the rating of the insurer, if any, as
34 published by a nationally recognized rating
35 organization;

36 (3) the types of coverages available to a
37 consumer through any insurer writing insurance in this
38 state;

39 (4) the insurer's admitted
40 assets-to-liabilities ratio; and

41 (5) other appropriate information
42 collected and maintained by the department.

43 Revised Law

44 Sec. 521.053. PUBLICITY REQUIREMENTS. The department
45 shall publicize the department's toll-free telephone number in

1 public service announcements and publish that number in telephone
2 books throughout the state, as the department finds appropriate.
3 (V.T.I.C. Art. 1.35D, Sec. (e).)

4 Source Law

5 (e) The toll-free telephone number shall be
6 publicized in public service announcements and
7 published in telephone books throughout the state, as
8 the board finds appropriate.

9 Revisor's Note

10 Section (e), V.T.I.C. Article 1.35D, refers to
11 the State Board of Insurance. Chapter 685, Acts of the
12 73rd Legislature, Regular Session, 1993, abolished the
13 board and transferred its functions to the
14 commissioner of insurance and the Texas Department of
15 Insurance. Throughout this chapter, references to the
16 board have been changed appropriately.

17 Revised Law

18 Sec. 521.054. RECORD OF INQUIRY OR COMPLAINT REQUIRED. The
19 department shall maintain a written record of each inquiry and
20 complaint received through the department's toll-free telephone
21 number. (V.T.I.C. Art. 1.35D, Sec. (c).)

22 Source Law

23 (c) The department shall maintain a written
24 record of all inquiries and complaints received
25 through the toll-free telephone number.

26 Revised Law

27 Sec. 521.055. COMPLAINT NOTIFICATION SYSTEM. The
28 department shall establish a system to notify insurers by
29 electronic transmission to a facsimile machine or other appropriate
30 system of complaints received by the department through the
31 department's toll-free telephone number. (V.T.I.C. Art. 1.35D,
32 Sec. (d).)

33 Source Law

34 (d) The department shall establish a system for
35 communicating complaints received through the
36 toll-free telephone number to insurers by electronic
37 transmission to a facsimile machine or other
38 appropriate system.

1 Revised Law

2 Sec. 521.056. INFORMATION BULLETIN TO ACCOMPANY POLICY.
3 Each insurer that delivers, issues for delivery, or renews an
4 insurance policy in this state shall include with the policy an
5 information bulletin that includes:

- 6 (1) the department's toll-free telephone number; and
7 (2) a description of the services available through
8 the department's toll-free telephone number. (V.T.I.C.
9 Art. 1.35D, Sec. (f).)

10 Source Law

11 (f) Each insurer that delivers, issues for
12 delivery, or renews an insurance policy in this state
13 shall include with the policy an information bulletin
14 including the toll-free telephone number and
15 describing the services offered through the number.

16 [Sections 521.057-521.100 reserved for expansion]

17 SUBCHAPTER C. HEALTH MAINTENANCE ORGANIZATION OR
18 INSURER TOLL-FREE NUMBER FOR INFORMATION AND COMPLAINTS

19 Revised Law

20 Sec. 521.101. APPLICABILITY OF SUBCHAPTER. (a) Except as
21 provided by Subsection (b), this subchapter applies to a health
22 maintenance organization authorized to engage in the business of a
23 health maintenance organization in this state or an insurer
24 authorized to engage in the business of insurance in this state,
25 including:

- 26 (1) a capital stock insurance company;
27 (2) a mutual insurance company;
28 (3) a title insurance company;
29 (4) a fraternal benefit society;
30 (5) a local mutual aid association;
31 (6) a statewide mutual assessment company;
32 (7) a county mutual insurance company;
33 (8) a Lloyd's plan;
34 (9) a reciprocal or interinsurance exchange;
35 (10) a stipulated premium company;
36 (11) a group hospital service corporation; and

1 (12) a risk retention group.

2 (b) This subchapter does not apply to a health maintenance
3 organization or insurer:

4 (1) that has gross initial premium receipts collected
5 in this state of less than \$2 million each year; or

6 (2) with regard to fidelity, surety, or guaranty
7 bonds. (V.T.I.C. Art. 21.71, Secs. (a), (b).)

8 Source Law

9 Art. 21.71. (a) Except as provided in
10 Subsection (b) of this article, this article applies
11 to any insurer authorized to do business as an
12 insurance company or to provide insurance in this
13 state, including:

- 14 (1) a capital stock company;
- 15 (2) a mutual company;
- 16 (3) a title insurance company;
- 17 (4) a fraternal benefit society;
- 18 (5) a local mutual aid association;
- 19 (6) a statewide mutual assessment company;
- 20 (7) a county mutual insurance company;
- 21 (8) a Lloyd's plan company;
- 22 (9) a reciprocal or interinsurance
23 exchange;
- 24 (10) a stipulated premium insurance
25 company;
- 26 (11) a group hospital service company;
- 27 (12) a health maintenance organization;
- 28 and
- 29 (13) a risk retention group.

30 (b) This article does not apply to an insurer
31 whose gross initial premium receipts collected in this
32 state are less than \$2 million a year or to an insurer
33 with regard to fidelity, surety, or guaranty bonds.

34 Revisor's Note

35 Section (a), V.T.I.C. Article 21.71, provides
36 that the article applies to an "insurer" authorized to
37 do business or to provide insurance in this state,
38 including certain listed entities. Included among the
39 listed entities is a "health maintenance
40 organization," which is not a traditional insurer.
41 The revised law is drafted to reflect its application
42 to both traditional insurers and health maintenance
43 organizations, and terminology consistent with that
44 application is added throughout this subchapter.

45 Revised Law

46 Sec. 521.102. HEALTH MAINTENANCE ORGANIZATION OR INSURER

1 TOLL-FREE NUMBER FOR INFORMATION AND COMPLAINTS. A health
2 maintenance organization or insurer shall maintain a toll-free
3 telephone number to:

4 (1) provide information concerning evidences of
5 coverage or policies issued by the health maintenance organization
6 or insurer; and

7 (2) receive complaints from enrollees or
8 policyholders. (V.T.I.C. Art. 21.71, Sec. (c).)

9 Source Law

10 (c) Each insurer in this state shall maintain a
11 toll-free telephone number to provide information
12 concerning policies issued by the insurer and to
13 accept complaints from policyholders.

14 Revisor's Note

15 Section (c), V.T.I.C. Article 21.71, requires a
16 health maintenance organization or insurer "in this
17 state" to maintain a toll-free telephone number. The
18 revised law omits the quoted phrase as redundant
19 because Section (a), V.T.I.C. Article 21.71, revised
20 as Section 521.101(a), limits the applicability of
21 Section (c), revised as this section, to a health
22 maintenance organization or insurer authorized to
23 engage in business in this state.

24 Revised Law

25 Sec. 521.103. INFORMATION INCLUDED IN EVIDENCE OF COVERAGE
26 OR POLICY. (a) Each health maintenance organization or insurer
27 that delivers, issues for delivery, or renews an evidence of
28 coverage or insurance policy in this state shall print on the
29 evidence of coverage or policy the health maintenance
30 organization's or insurer's toll-free telephone number.

31 (b) The commissioner may adopt rules governing the manner in
32 which the toll-free telephone number appears on the evidence of
33 coverage or insurance policy. (V.T.I.C. Art. 21.71, Sec. (d).)

34 Source Law

35 (d) Each insurer that delivers, issues for
36 delivery, or renews an insurance policy in this state
37 shall print on the policy the insurer's toll-free

1 telephone number. The board may adopt rules governing
2 the manner in which the number appears on the policy.

3 CHAPTER 522. CONSUMER INFORMATION IN SPANISH

4 Sec. 522.001. INFORMATIONAL SHEET FOR TEXAS PERSONAL

5 AUTOMOBILE POLICIES 184

6 CHAPTER 522. CONSUMER INFORMATION IN SPANISH

7 Revised Law

8 Sec. 522.001. INFORMATIONAL SHEET FOR TEXAS PERSONAL

9 AUTOMOBILE POLICIES. (a) The commissioner shall develop or adopt
10 an informational sheet in the Spanish language to provide a general
11 explanation of the terms most commonly used in the Texas personal
12 automobile insurance policy. The department shall make the
13 informational sheet available to the public.

14 (b) The informational sheet is intended to provide only a
15 general explanation of insurance terms used in the Texas personal
16 automobile insurance policy and is not intended to alter any
17 rights, obligations, or responsibilities of the contracting
18 parties. All other applicable laws, including provisions of this
19 code, apply regardless of whether an informational sheet is used.

20 (c) The informational sheet must include a disclaimer in the
21 Spanish language, prominently printed in 10-point boldfaced type at
22 the top of the informational sheet, that contains the following:

23 "This document is for informational purposes only
24 and is not intended to alter or replace the insurance
25 policy. Additionally, this informational sheet is not
26 intended to fully set out your rights and obligations
27 or the rights and obligations of the insurer. If you
28 have questions about your insurance, you should
29 consult your insurance agent, the insurer, or the
30 language of the insurance policy." (V.T.I.C.
31 Art. 1.35E.)

32 Source Law

33 Art. 1.35E. (a) The commissioner shall develop
34 or adopt an informational sheet in the Spanish
35 language to provide a general explanation of the terms
36 most commonly used in the Texas personal automobile
37 insurance policy. The department shall make the

1 informational sheet required by this article available
2 to the public.

3 (b) The informational sheet is intended to
4 provide only a general explanation of insurance terms
5 used in the Texas personal automobile insurance policy
6 and is not intended to alter any rights, obligations,
7 or responsibilities of the contracting parties. All
8 other applicable laws, including provisions of this
9 code, apply regardless of whether an informational
10 sheet is used.

11 (c) An informational sheet developed by the
12 commissioner must include a disclaimer, prominently
13 printed in 10-point boldface type at the top of the
14 informational sheet in the Spanish language, that
15 contains the following:

16 "This document is for informational purposes only
17 and is not intended to alter or replace the insurance
18 policy. Additionally, this informational sheet is not
19 intended to fully set out your rights and obligations
20 or the rights and obligations of the insurance
21 company. If you have questions about your insurance,
22 you should consult your insurance agent, the insurance
23 company, or the language of the insurance policy."

24 CHAPTER 523. MARKET ASSISTANCE PROGRAM FOR RESIDENTIAL
25 PROPERTY INSURANCE

26 SUBCHAPTER A. GENERAL PROVISIONS

27 Sec. 523.001. DEFINITION 186
28 Sec. 523.002. RULES 186
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30 [Sections 523.004-523.050 reserved for expansion]

31 SUBCHAPTER B. OPERATION OF MARKET ASSISTANCE PROGRAM

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34 Sec. 523.053. EXECUTIVE COMMITTEE 189
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37 [Sections 523.056-523.100 reserved for expansion]

38 SUBCHAPTER C. PARTICIPATION IN MARKET ASSISTANCE PROGRAM

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40 Sec. 523.102. APPLICATION ASSISTANCE AND REFERRALS 194
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43 Sec. 523.105. NONPAYMENT OF PREMIUM OR SUBMISSION OF

44 FRAUDULENT CLAIM 196

45 [Sections 523.106-523.150 reserved for expansion]

1 SUBCHAPTER D. PROGRAM AGENTS

2 Sec. 523.151. TYPES OF AGENTS 196
3 Sec. 523.152. SHARING OF AGENT COMMISSIONS 197

4 [Sections 523.153-523.200 reserved for expansion]

5 SUBCHAPTER E. MARKET ASSISTANCE PROGRAM REVIEW;
6 PROGRAM TERMINATION

7 Sec. 523.201. COLLECTION OF PROGRAM INFORMATION 198
8 Sec. 523.202. PERIODIC REVIEW OF PROGRAM. 198
9 Sec. 523.203. TERMINATION OF PROGRAM 199

10 CHAPTER 523. MARKET ASSISTANCE PROGRAM FOR RESIDENTIAL
11 PROPERTY INSURANCE

12 SUBCHAPTER A. GENERAL PROVISIONS

13 Revised Law

14 Sec. 523.001. DEFINITION. In this chapter, "residential
15 property insurance" means insurance provided by a homeowners policy
16 or residential fire and allied lines policy against loss incurred
17 at a fixed location to real or tangible personal property. The term
18 does not include insurance against loss provided by a farm and ranch
19 owners policy. (V.T.I.C. Art. 21.49-12, Sec. 1(a) (part).)

20 Source Law

21 (a) . . . For purposes of this article,
22 residential property insurance means insurance
23 against loss to real or tangible personal property at a
24 fixed location provided in a homeowners policy or a
25 residential fire and allied lines policy, but does not
26 include a farm and ranch owners policy. . . .

27 Revised Law

28 Sec. 523.002. RULES. In addition to the plan of operation
29 adopted under Subchapter B, the commissioner may adopt appropriate
30 rules to accomplish the purposes of this chapter. (V.T.I.C.
31 Art. 21.49-12, Sec. 8.)

32 Source Law

33 Sec. 8. The commissioner is authorized to adopt
34 rules in addition to the plan of operation that are
35 appropriate to accomplish the purposes of this
36 article.

37 Revised Law

38 Sec. 523.003. IMMUNITY. The market assistance program,

1 the members of the executive committee, and participating insurers
2 and agents are not personally liable for:

3 (1) an act performed in good faith in the scope of the
4 person's authority as determined under this chapter; or

5 (2) damages arising from the person's official acts or
6 omissions, other than a corrupt or malicious act or omission.

7 (V.T.I.C. Art. 21.49-12, Sec. 7.)

8 Source Law

9 Sec. 7. The program, executive committee
10 members, and participating insurers and agents are not
11 personally liable for any act performed in good faith
12 within the scope of the person's authority as
13 determined under this article or for damages
14 occasioned by his or her official acts or omissions
15 except for an act or omission that is corrupt or
16 malicious.

17 [Sections 523.004-523.050 reserved for expansion]

18 SUBCHAPTER B. OPERATION OF MARKET ASSISTANCE PROGRAM

19 Revised Law

20 Sec. 523.051. MARKET ASSISTANCE PROGRAM. (a) The market
21 assistance program is a voluntary program designed to assist
22 applicants for insurance and insureds in this state in obtaining
23 residential property insurance coverage in underserved areas. The
24 commissioner by rule shall designate underserved areas using the
25 standards described by Section 1, Article 5.35-3.

26 (b) The commissioner shall establish the types of risks for
27 which the market assistance program will provide assistance.

28 (c) The market assistance program may not provide
29 assistance regarding windstorm and hail insurance coverage for a
30 risk eligible for that coverage under Article 21.49. (V.T.I.C.
31 Art. 21.49-12, Secs. 1(a) (part), (b).)

32 Source Law

33 Art. 21.49-12

34 Sec. 1. (a) The commissioner shall establish a
35 voluntary mechanism to be called a market assistance
36 program to assist insureds in Texas in obtaining
37 residential property insurance coverage in
38 underserved areas, which shall be determined and
39 designated by the commissioner by rule using the
40 standards specified in Section 1, Article 5.35-3, of
41 this code. . . . The types of risks to be assisted
42 under the market assistance program will be

1 established by the commissioner. . . .

2 (b) The market assistance program established
3 under this article may not provide assistance with
4 respect to windstorm and hail insurance coverage for a
5 risk eligible for that coverage under Article 21.49 of
6 this code.

7 Revisor's Note

8 (1) Section 1(a), V.T.I.C. Article 21.49-12,
9 provides that "[t]he commissioner [of insurance] shall
10 establish" a market assistance program. The revised
11 law omits the requirement to establish the program as
12 executed.

13 (2) Section 1(a), V.T.I.C. Article 21.49-12,
14 states that the purpose of the market assistance
15 program is to assist "insureds" in obtaining certain
16 insurance coverage. The revised law refers to
17 "applicants for insurance" in addition to "insureds"
18 to reflect the clear intent of the legislature that an
19 applicant for insurance who is not currently an
20 insured is also intended to benefit from the program.

21 (3) Section 1(a), V.T.I.C. Article 21.49-12,
22 refers to underserved areas "determined and
23 designated" by the commissioner of insurance. The
24 revised law omits the reference to "determined" as
25 unnecessary because, in context, the commissioner
26 necessarily determines underserved areas in the
27 process of designating the areas.

28 Revised Law

29 Sec. 523.052. MARKET ASSISTANCE PROGRAM DIVISION. The
30 department shall operate a market assistance program division.
31 (V.T.I.C. Art. 21.49-12, Sec. 1(a) (part).)

32 Source Law

33 (a) . . . A market assistance program division
34 shall be established in and operated by the Texas
35 Department of Insurance.

36 Revisor's Note

37 Section 1(a), V.T.I.C. Article 21.49-12,
38 requires that a market assistance program division "be

1 established" in the Texas Department of Insurance.
2 The revised law omits the requirement to establish the
3 division as executed.

4 Revised Law

5 Sec. 523.053. EXECUTIVE COMMITTEE. (a) The market
6 assistance program is administered by an executive committee.

7 (b) The executive committee consists of 11 members
8 appointed by the commissioner as follows:

9 (1) five members who represent the interests of
10 insurers;

11 (2) four public members; and

12 (3) two members who are general property and casualty
13 agents.

14 (c) Each member of the executive committee who represents
15 the interests of insurers must be a full-time employee of an
16 authorized insurer.

17 (d) The commissioner or the commissioner's designated
18 representative serves as an ex officio member of the executive
19 committee and must be present at each executive committee meeting.

20 (e) The executive committee shall be available to advise and
21 consult with the commissioner regarding the administration of the
22 market assistance program. (V.T.I.C. Art. 21.49-12, Secs. 2(a)
23 (part), 3.)

24 Source Law

25 Sec. 2. (a) The executive committee . . .
26 shall be available to advise and consult with the
27 commissioner with regard to the administration of the
28 program. . . .

29 Sec. 3. (a) The program shall be administered
30 by an executive committee composed of 11 members
31 appointed by the commissioner:

32 (1) five members who represent the
33 interests of insurers;

34 (2) four public members; and

35 (3) two members who are licensed local
36 recording agents.

37 (b) To be eligible to serve on the executive
38 committee as a representative of insurers, a person
39 must be a full-time employee of an authorized insurer.

40 (c) The commissioner or the commissioner's
41 designated representative shall be an ex officio
42 member of the executive committee and must be present

1 in every meeting of the executive committee.

2 Revisor's Note

3 (1) Section 3(a)(3), V.T.I.C. Article 21.49-12,
4 refers to "licensed" agents. The revised law omits
5 "licensed" as unnecessary in this context because a
6 person may not act as an agent unless the person holds
7 a license. See Section 4001.101 of this code.

8 (2) Section 3(a)(3), V.T.I.C. Article 21.49-12,
9 refers to "local recording agents." Throughout this
10 chapter, the revised law substitutes "general property
11 and casualty agents" for "local recording agents"
12 because the term "local recording agent" was
13 eliminated by Chapter 703, Acts of the 77th
14 Legislature, Regular Session, 2001, and a person who
15 performs the duties formerly performed by a local
16 recording agent in the context of residential property
17 insurance is now regulated as a "general property and
18 casualty agent" under Chapter 4051 of this code.

19 Revised Law

20 Sec. 523.054. PLAN OF OPERATION. (a) The operation and
21 management of the market assistance program is governed by a plan of
22 operation adopted by rule by the commissioner.

23 (b) In addition to the other requirements specified by this
24 chapter, the plan of operation must include provisions regarding
25 types of coverage, policy forms and terms, application forms,
26 eligibility, and the overall operation of the market assistance
27 program.

28 (c) The plan of operation may provide for subcommittees
29 necessary to administer the market assistance program. (V.T.I.C.
30 Art. 21.49-12, Secs. 2(a) (part), (b) (part), (c).)

31 Source Law

32 Sec. 2. (a) [The executive committee shall
33 . . . submit] the plan of operation to the
34 commissioner for adoption by rule and The
35 plan of operation shall indicate types of coverage,
36 policy forms and terms, application forms,
37 eligibility, and overall operation of the

1 program. . . .

2 (b) The plan of operation shall include, but is
3 not limited to, the following provisions:

4 . . .
5 (c) The plan of operation may provide for
6 subcommittees that are necessary to carry out the
7 functions of a program.

8 Revisor's Note

9 (1) Section 2(a), V.T.I.C. Article 21.49-12, as
10 amended by Section 5, Chapter 415, Acts of the 74th
11 Legislature, Regular Session, 1995, requires the
12 executive committee to submit a plan of operation to
13 the commissioner of insurance for approval within 180
14 days following the effective date of Chapter 415 and
15 provides that if the executive committee fails to do
16 so, the Texas Department of Insurance shall submit a
17 plan to the commissioner for adoption by rule. Chapter
18 415, Acts of the 74th Legislature, Regular Session,
19 1995, took effect August 28, 1995. Accordingly, the
20 revised law omits the provision as executed. The
21 omitted law reads:

22 Sec. 2. (a) The executive committee
23 shall develop and submit [the plan of
24 operation to the commissioner] If
25 the executive committee fails to submit a
26 suitable plan of operation within 180 days
27 following the effective date of this
28 article, or . . . [the department shall
29 develop and submit to the commissioner] a
30 plan of operation . . . [and the
31 commissioner shall, after notice and
32 hearing, adopt by rule] the plan of
33 operation developed by the department or
34

35 (2) Section 2(b), V.T.I.C. Article 21.49-12,
36 provides that the plan of operation required by that
37 article shall "include, but is not limited to" the
38 specified provisions. The revised law omits the
39 phrase "but is not limited to" and similar phrases are
40 omitted throughout this chapter as unnecessary because
41 Section 311.005(13), Government Code (Code
42 Construction Act), and Section 312.011(19),
43 Government Code, provide that "includes" and

1 "including" are terms of enlargement and not of
2 limitation and do not create a presumption that
3 components not expressed are excluded.

4 Revised Law

5 Sec. 523.055. AMENDMENT OF PLAN OF OPERATION. (a) The
6 executive committee may develop amendments to the plan of operation
7 and submit the amendments to the commissioner for adoption by rule.

8 (b) If the executive committee fails to submit suitable
9 amendments to the plan of operation, the department shall develop
10 and submit to the commissioner suitable amendments and the
11 commissioner shall, after notice and hearing, adopt the amendments
12 by rule. (V.T.I.C. Art. 21.49-12, Sec. 2(a) (part).)

13 Source Law

14 Sec. 2. (a) [The executive committee shall
15 develop and submit the plan of operation to the
16 commissioner for adoption by rule and] . . . if at any
17 time thereafter the executive committee fails to
18 submit suitable amendments to the plan of operation,
19 the department shall develop and submit to the
20 commissioner [a plan of operation] and thereafter any
21 amendments thereto, and the commissioner shall, after
22 notice and hearing, adopt by rule . . . any amendments
23 to the plan of operation. . . .

24 Revisor's Note

25 Section 2(a), V.T.I.C. Article 21.49-12,
26 requires the executive committee to develop the market
27 assistance program plan of operation and requires the
28 Texas Department of Insurance to submit to the
29 commissioner of insurance amendments to the plan if
30 the executive committee fails to submit suitable
31 amendments. For clarity, the revised law makes
32 explicit the authority implied by the section for the
33 executive committee to develop amendments to the plan
34 and submit the amendments to the commissioner for
35 adoption by rule.

36 [Sections 523.056-523.100 reserved for expansion]

1 SUBCHAPTER C. PARTICIPATION IN MARKET ASSISTANCE PROGRAM

2 Revised Law

3 Sec. 523.101. PARTICIPATION BY INSURERS. (a) An insurer
4 authorized to engage in the business of property or casualty
5 insurance that writes residential property insurance in this state,
6 including a Lloyd's plan or a reciprocal or interinsurance
7 exchange, may voluntarily participate in the market assistance
8 program. The commissioner may not permit an insurer to condition
9 its participation in the program in a manner that is inequitable to
10 the participants.

11 (b) Notwithstanding Subsection (a), the commissioner may
12 make insurer participation in the market assistance program
13 mandatory. The plan of operation must contain the criteria under
14 which the commissioner may make insurer participation in the market
15 assistance program mandatory.

16 (c) Each participating insurer is entitled to individually
17 evaluate a risk and apply rates under the market assistance program
18 in accordance with the provisions of this code applicable to the
19 insurer. (V.T.I.C. Art. 21.49-12, Secs. 2(a) (part), (b) (part).)

20 Source Law

21 (a) . . . All insurers licensed to write
22 property or casualty insurance and actually writing
23 residential property insurance in this state,
24 including Lloyds, reciprocals, or interinsurance
25 exchanges, may participate in the program unless
26 insurer participation is made mandatory by the
27 commissioner based on criteria provided in the plan of
28 operation, but the commissioner may not permit an
29 insurer to condition its participation in a manner
30 that is inequitable to the participants.

31 (b) [The plan of operation shall include, but is
32 not limited to, the following provisions:]

33 . . .
34 (2) Each insurer has the right to
35 individually evaluate the risk and apply the rates in
36 accordance with the provisions of this code applicable
37 to each insurer.

38 . . .
39 (7) The plan of operation shall contain
40 criteria under which the commissioner may make insurer
41 participation in the program mandatory.

42 Revisor's Note

43 Section 2(a), V.T.I.C. Article 21.49-12, refers
44 to an insurer "licensed to write" property or casualty

1 insurance in this state, meaning an insurer that holds
2 a certificate of authority under which the insurer is
3 authorized to engage in the business of writing
4 property or casualty insurance in this state. The
5 revised law substitutes "authorized to engage in the
6 business of" for "licensed to write" for consistent
7 use of terminology within this code.

8 Revised Law

9 Sec. 523.102. APPLICATION ASSISTANCE AND REFERRALS. The
10 department may:

11 (1) assist an applicant for coverage through the
12 market assistance program in completing an initial application; and

13 (2) refer the applicant to one or more participating
14 insurers. (V.T.I.C. Art. 21.49-12, Sec. 4(a).)

15 Source Law

16 Sec. 4. (a) The department may:

17 (1) assist an applicant for coverage
18 through the market assistance program in completing an
19 initial application; and

20 (2) refer the applicant to one or more
21 participating companies.

22 Revised Law

23 Sec. 523.103. APPLICATION FOR ASSISTANCE. (a) An
24 application for assistance must be addressed to the market
25 assistance program at the department.

26 (b) An application must be accompanied by a copy of a
27 current notice of nonrenewal or cancellation of coverage and a
28 current declination letter from at least one other insurer that
29 writes the coverage sought, except that an applicant who does not
30 have previous residential property insurance coverage must provide
31 copies of current declination letters from at least two
32 unaffiliated insurers that write the coverage sought. (V.T.I.C.
33 Art. 21.49-12, Sec. 2(b) (part).)

34 Source Law

35 (b) [The plan of operation shall include, but is
36 not limited to, the following provisions:]

37 (1) Applications for assistance shall be
38 addressed to the Market Assistance Program at the

1 Texas Department of Insurance. Each application must
2 be accompanied by a copy of a current nonrenewal or
3 cancellation notice and a current declination letter
4 from at least one other insurer writing the coverage
5 sought. Applicants not having previous residential
6 property insurance coverage must provide copies of
7 current declination letters from at least two
8 unaffiliated insurers writing the coverage sought.
9

. . .

10 Revised Law

11 Sec. 523.104. INSURER ACTION ON APPLICATION. (a) Not
12 later than the 30th day after the date an insurer receives an
13 application, the insurer shall:

- 14 (1) quote a premium;
15 (2) indicate its refusal to quote a premium; or
16 (3) request additional time to consider a premium
17 quote.

18 (b) If the insurer quotes a premium, the insurer shall
19 notify the applicant or the applicant's agent, if an agent is used,
20 so that the placement of the insurance may be completed if the
21 applicant accepts the coverage at the quoted premium.

22 (c) The insurer may provide a premium quote on the same
23 coverage basis for which the insurer normally provides insurance in
24 this state using the insurer's underwriting guidelines and applying
25 rates determined in accordance with the provisions of this code
26 applicable to the insurer. (V.T.I.C. Art. 21.49-12, Sec. 2(b)
27 (part).)

28 Source Law

29 (b) [The plan of operation shall include, but is
30 not limited to, the following provisions:]

31 . . .
32 (3) Each insurer has the option of
33 providing a premium quote on the same coverage basis
34 for which it normally provides insurance in this state
35 using its own underwriting guidelines and the rates
36 determined in accordance with the provisions of this
37 code applicable to each insurer.

38 (4) An insurer shall make its premium
39 quote, indicate its refusal to quote, or make a request
40 for additional time within 30 days of receiving the
41 application.

42 (5) If a premium quote is made, the insurer
43 shall notify the applicant or notify the applicant's
44 agent, if an agent is used, so that the placement of
45 the insurance may be completed, if the applicant
46 accepts the coverage at the premium quoted.
47

. . .

1 Revised Law

2 Sec. 523.105. NONPAYMENT OF PREMIUM OR SUBMISSION OF
3 FRAUDULENT CLAIM. If an insurer cancels or does not renew coverage
4 for nonpayment of premium or submission of a fraudulent claim, an
5 applicant is ineligible to subsequently apply to the market
6 assistance program for the same coverage for the same risk.
7 (V.T.I.C. Art. 21.49-12, Sec. 2(b) (part).)

8 Source Law

9 (b) [The plan of operation shall include, but is
10 not limited to, the following provisions:]

11 . . .
12 (6) An applicant is not eligible to apply
13 to the program again for the same coverage for the same
14 risk if the insurer cancels or nonrenews coverage for
15 nonpayment of premium or submission of a fraudulent
16 claim.
17 . . .

18 [Sections 523.106-523.150 reserved for expansion]

19 SUBCHAPTER D. PROGRAM AGENTS

20 Revised Law

21 Sec. 523.151. TYPES OF AGENTS. (a) Notwithstanding other
22 law, the market assistance program may have both originating agents
23 and issuing agents.

24 (b) An originating agent may complete on behalf of an
25 applicant an application for insurance to submit to the market
26 assistance program. An applicant is not required to submit the
27 application through an originating agent. If an originating agent
28 is used, the originating agent is not required to be appointed to
29 represent the ultimate insurer.

30 (c) An issuing agent must be appointed to represent the
31 ultimate insurer. The issuing agent shall perform the customary
32 duties of a general property and casualty agent, including:

33 (1) signing, executing, and delivering insurance
34 policies;

35 (2) maintaining a record of the business;

36 (3) examining and inspecting the risk; and

37 (4) receiving and collecting premiums.

38 (d) A person may act as both the originating agent and the

1 issuing agent. If the originating agent and the issuing agent are
2 not the same person, the originating agent may not be held to be the
3 agent of the insurer unless the agent is appointed as provided by
4 Chapter 4051. (V.T.I.C. Art. 21.49-12, Secs. 4(b), (c), (d), (f).)

5 Source Law

6 (b) Notwithstanding any other provision of law,
7 a market assistance program may have two categories of
8 agents:

- 9 (1) an originating agent; and
10 (2) an issuing agent.

11 (c) An originating agent may complete an
12 application for insurance on behalf of an insured for
13 submission to the program, but an applicant is not
14 required to submit the application through an
15 originating agent. If an originating agent is used,
16 the originating agent is not required to be appointed
17 to represent the ultimate insurer.

18 (d) An issuing agent must be appointed to
19 represent the ultimate insurer and shall perform all
20 of the customary duties of a local recording agent
21 including but not limited to the following:

- 22 (1) signing, executing, and delivering
23 policies of insurance;
24 (2) maintaining a record of the business;
25 (3) examining and inspecting the risk; and
26 (4) receiving and collecting premiums.

27 (f) The originating agent, if any, and the
28 issuing agent may be the same person. If the
29 originating agent and the issuing agent are not the
30 same person, the originating agent may not be held to
31 be the agent of the insurer unless there is an
32 appointment as specified by Article 21.14 of this
33 code.

34 Revised Law

35 Sec. 523.152. SHARING OF AGENT COMMISSIONS. (a) An
36 originating agent shall share commissions with an issuing agent as
37 required by the market assistance program plan of operation if the
38 originating agent holds a license as:

- 39 (1) a general property and casualty agent; or
40 (2) a salaried representative for one or more insurers

41 whose plan of operation does not contemplate the use of general
42 property and casualty agents.

43 (b) The market assistance program may not share in
44 commissions. (V.T.I.C. Art. 21.49-12, Secs. 4(e), (g).)

45 Source Law

46 (e) The originating agent, if any, shall share
47 commissions, as required by the market assistance
48 program plan of operation, with the issuing agent if

1 the originating agent holds a license as either a local
2 recording agent or as a salaried representative for
3 those companies whose plan of operation does not
4 contemplate the use of local recording agents.

5 (g) The program may not share in commissions.

6 [Sections 523.153-523.200 reserved for expansion]

7 SUBCHAPTER E. MARKET ASSISTANCE PROGRAM REVIEW;

8 PROGRAM TERMINATION

9 Revised Law

10 Sec. 523.201. COLLECTION OF PROGRAM INFORMATION.

11 Information concerning the number and type of applications received
12 and placed by the market assistance program and other information
13 about the program the executive committee or the commissioner
14 considers appropriate shall be collected. (V.T.I.C.
15 Art. 21.49-12, Sec. 6(a).)

16 Source Law

17 Sec. 6. (a) Information concerning the number
18 and type of applications received and placed, and such
19 other information, as deemed appropriate by the
20 executive committee or the commissioner, shall be
21 collected.

22 Revised Law

23 Sec. 523.202. PERIODIC REVIEW OF PROGRAM. (a) The
24 executive committee shall review the demand for and performance of
25 the market assistance program at least annually, as necessary.

26 (b) After each review, the executive committee shall report
27 to the commissioner regarding:

28 (1) the need to continue operating the voluntary
29 market assistance program;

30 (2) the need to establish a mandatory market
31 assistance program;

32 (3) the need to establish a FAIR (Fair Access to
33 Insurance Requirements) Plan under Article 21.49A; or

34 (4) other recommendations the executive committee
35 considers appropriate. (V.T.I.C. Art. 21.49-12, Sec. 6(b)
36 (part).)

37 Source Law

38 (b) The executive committee shall review the

1 demand for and performance of the program six months
2 following the approval of the plan of operation, and at
3 least annually thereafter, as necessary. After each
4 such review the executive committee shall report to
5 the commissioner as to the necessity for continued
6 operation of the voluntary program, need for
7 establishment of a mandatory program, or the need for
8 establishment of a FAIR Plan pursuant to Article
9 21.49A of this code, or other recommendations the
10 executive committee deems appropriate. . . .

11 Revisor's Note

12 (1) Section 6(b), V.T.I.C. Article 21.49-12,
13 refers to a review of the market assistance program to
14 be performed "six months following the approval of the
15 plan of operation." Section 2, V.T.I.C. Article
16 21.49-12, as amended by Section 5, Chapter 415, Acts of
17 the 74th Legislature, Regular Session, 1995, requires
18 the executive committee to submit a plan of operation
19 to the commissioner of insurance for approval within
20 180 days following the effective date of the act and
21 requires the Texas Department of Insurance to submit a
22 plan to the commissioner for approval if the executive
23 committee fails to do so. Chapter 415, Acts of the
24 74th Legislature, Regular Session, 1995, took effect
25 August 28, 1995. Accordingly, the revised law omits
26 the quoted language as executed.

27 (2) Section 6(b), V.T.I.C. Article 21.49-12,
28 refers to the establishment of a "FAIR Plan" under
29 V.T.I.C. Article 21.49A. Under Article 21.49A, "FAIR"
30 is an acronym for "Fair Access to Insurance
31 Requirements," and the revised law is drafted
32 accordingly.

33 Revised Law

34 Sec. 523.203. TERMINATION OF PROGRAM. The department may
35 terminate the market assistance program only on the commissioner's
36 approval. (V.T.I.C. Art. 21.49-12, Sec. 6(b) (part).)

37 Source Law

38 (b) . . . The program shall be terminated only
39 upon approval of the commissioner, but

1 Revisor's Note

2 Section 6(b), V.T.I.C. Article 21.49-12,
3 provides that the market assistance program may not be
4 terminated until at least 48 months have elapsed
5 following the commencement date of the initial plan of
6 operation. The revised law omits the provision as no
7 longer necessary because, according to information
8 from the Texas Department of Insurance, the initial
9 plan of operation took effect October 1, 1996, and more
10 than 48 months have elapsed since that date. The
11 omitted law reads:

12 (b) . . . [The program shall be
13 terminated] . . . in no event earlier than
14 48 months following the commencement date
15 of the initial plan of operation.

16 [Chapters 524-540 reserved for expansion]

17 SUBTITLE C. DECEPTIVE, UNFAIR, AND PROHIBITED PRACTICES

18 CHAPTER 541. UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE
19 ACTS OR PRACTICES

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5 CHAPTER 541. UNFAIR METHODS OF COMPETITION AND UNFAIR OR DECEPTIVE
 6 ACTS OR PRACTICES

7 SUBCHAPTER A. GENERAL PROVISIONS

8 Revised Law

9 Sec. 541.001. PURPOSE. The purpose of this chapter is to
 10 regulate trade practices in the business of insurance by:

11 (1) defining or providing for the determination of
 12 trade practices in this state that are unfair methods of
 13 competition or unfair or deceptive acts or practices; and

14 (2) prohibiting those trade practices. (V.T.I.C.
 15 Art. 21.21, Sec. 1(a).)

16 Source Law

17 Art. 21.21
 18 Sec. 1. (a) The purpose of this Act is to
 19 regulate trade practices in the business of insurance
 20 by defining, or providing for the determination of,
 21 all such practices in this state which constitute
 22 unfair methods of competition or unfair or deceptive
 23 acts or practices and by prohibiting the trade
 24 practices so defined or determined.

25 Revised Law

26 Sec. 541.002. DEFINITIONS. In this chapter:

27 (1) "Knowingly" means actual awareness of the falsity,
 28 unfairness, or deceptiveness of the act or practice on which a claim
 29 for damages under Subchapter D is based. Actual awareness may be
 30 inferred if objective manifestations indicate that a person acted
 31 with actual awareness.

32 (2) "Person" means an individual, corporation,
 33 association, partnership, reciprocal or interinsurance exchange,
 34 Lloyd's plan, fraternal benefit society, or other legal entity
 35 engaged in the business of insurance, including an agent, broker,
 36 adjuster, or life and health insurance counselor. (V.T.I.C.
 37 Art. 21.21, Secs. 2(a), (c).)

1 Source Law

2 Sec. 2. When used in this Article:

3 (a) "Person" shall mean any individual,
4 corporation, association, partnership, reciprocal
5 exchange, inter-insurer, Lloyds insurer, fraternal
6 benefit society, and any other legal entity engaged in
7 the business of insurance, including agents, brokers,
8 adjusters and life insurance counselors.

9 (c) "Knowingly" means actual awareness of
10 the falsity, unfairness, or deception of the act or
11 practice made the basis for a claim for damages under
12 Section 16 of this Article. "Actual awareness" may be
13 inferred where objective manifestations indicate that
14 a person acted with actual awareness.

15 Revisor's Note

16 (1) Section 2(a), V.T.I.C. Article 21.21,
17 refers to a "reciprocal exchange" and an
18 "inter-insurer." The revised law substitutes
19 "reciprocal or interinsurance exchange" for
20 "reciprocal exchange" and "inter-insurer" because
21 that is the term used in Chapter 942 of this code to
22 describe that type of insurer.

23 (2) Section 2(a), V.T.I.C. Article 21.21,
24 refers to "life insurance counselors." The revised
25 law substitutes "life and health insurance counselor"
26 because that is the term used in Chapter 4052 of this
27 code to refer to that type of insurance professional.
28 The term was changed from "life insurance counselor"
29 to "life and health insurance counselor" by Chapter
30 1530, Acts of the 76th Legislature, Regular Session,
31 1999.

32 (3) Section 2(b), V.T.I.C. Article 21.21,
33 defines "board" as the State Board of Insurance.
34 Chapter 685, Acts of the 73rd Legislature, Regular
35 Session, 1993, abolished the board and transferred its
36 functions to the commissioner of insurance and the
37 Texas Department of Insurance. Throughout this
38 chapter, references to the board have been changed
39 appropriately. The omitted law reads:

40 (b) "Board" shall mean the

1 State Board of Insurance.

2 Revised Law

3 Sec. 541.003. UNFAIR METHODS OF COMPETITION AND UNFAIR OR
4 DECEPTIVE ACTS OR PRACTICES PROHIBITED. A person may not engage in
5 this state in a trade practice that is defined in this chapter as or
6 determined under this chapter to be an unfair method of competition
7 or an unfair or deceptive act or practice in the business of
8 insurance. (V.T.I.C. Art. 21.21, Sec. 3.)

9 Source Law

10 Sec. 3. No person shall engage in this state in
11 any trade practice which is defined in this Act as, or
12 determined pursuant to this Act to be, an unfair method
13 of competition or an unfair or deceptive act or
14 practice in the business of insurance.

15 Revised Law

16 Sec. 541.004. VENUE FOR ACTIONS INVOLVING DEPARTMENT OR
17 COMMISSIONER. An action under this chapter in which the department
18 or commissioner is a party must be brought in a district court in
19 Travis County. (V.T.I.C. Art. 21.21, Sec. 21.)

20 Source Law

21 Sec. 21. Any action brought under this Article
22 shall be commenced in a district court of Travis
23 County, Texas, if the State Board of Insurance is a
24 party thereto.

25 Revised Law

26 Sec. 541.005. APPLICABILITY TO RISK RETENTION OR PURCHASING
27 GROUP. (a) A risk retention group or purchasing group, as those
28 terms are defined by Section 2, Article 21.54, not chartered in this
29 state may not engage in a trade practice in this state that is
30 defined as unlawful under this chapter.

31 (b) A risk retention group or purchasing group is subject to
32 this chapter and rules adopted under this chapter. (V.T.I.C.
33 Art. 21.21B.)

34 Source Law

35 Art. 21.21B. (a) A risk retention group or
36 purchasing group, as those terms are defined by
37 Article 21.54 of this code, that is not chartered in
38 this state, may not engage in any trade practice in
39 this state that is declared to be unlawful under
40 Article 21.21 of this code.

41 (b) A risk retention group or purchasing group

1 shall be subject to all of the provisions of Article
2 21.21 of this code and the rules and regulations
3 adopted under Article 21.21 of this code.

4 Revisor's Note

5 (1) Section (a), V.T.I.C. Article 21.21B,
6 refers to a trade practice that is "declared" to be
7 unlawful under V.T.I.C. Article 21.21. Throughout
8 this chapter, the revised law substitutes "defined"
9 for "declared" for consistency of terminology within
10 the chapter.

11 (2) Section (b), V.T.I.C. Article 21.21B,
12 refers to "rules and regulations." Throughout this
13 chapter, the revised law omits references to
14 "regulations" or substitutes references to "rules" for
15 references to "regulations" because in context the
16 terms are synonymous and under Section 311.005(5),
17 Government Code (Code Construction Act), a rule is
18 defined to include a regulation. That definition
19 applies to the revised law.

20 Revised Law

21 Sec. 541.006. PROHIBITED CONTENT OF CERTAIN INSURANCE
22 POLICIES. Notwithstanding any other provision of this code, it is
23 unlawful for an insurer engaged in the business of life, accident,
24 or health insurance to issue or deliver in this state a policy
25 containing the words "Approved by the Texas Department of
26 Insurance" or words of a similar meaning. (V.T.I.C. Art. 21.21,
27 Sec. 9(a).)

28 Source Law

29 Sec. 9. (a) Notwithstanding any other
30 provision of the Insurance Code (Acts 1951, 52nd
31 Legislature, page 868, Chapter 491) to the contrary,
32 it is hereby declared to be unlawful for any company
33 engaged in the business of life, accident or health
34 insurance to issue or deliver in this state a policy
35 containing the words "Approved by the Board of
36 Insurance Commissioners" or words of a similar import
37 or nature.

38 Revised Law

39 Sec. 541.007. IMMUNITY FROM PROSECUTION. (a) This

1 section applies to a person who requests to be excused from
2 attending and testifying at a hearing or from producing books,
3 papers, records, correspondence, or other documents at the hearing
4 on the ground that the testimony or evidence may:

5 (1) tend to incriminate the person; or

6 (2) subject the person to a penalty or forfeiture.

7 (b) A person who, notwithstanding a request described by
8 Subsection (a), is directed to provide the testimony or produce the
9 documents shall comply with that direction. Except as provided by
10 Subsection (c), the person may not be prosecuted or subjected to a
11 penalty or forfeiture for or on account of a transaction, matter, or
12 thing about which the person testifies or produces documents, and
13 the testimony or documents produced may not be received against the
14 person in a criminal action, investigation, or proceeding.

15 (c) A person who complies with a direction to testify or
16 produce documents is not exempt from prosecution or punishment for
17 perjury committed while testifying and the testimony or evidence
18 given or produced is admissible against the person in a criminal
19 action, investigation, or proceeding concerning the perjury, and
20 the person is not exempt from the denial, revocation, or suspension
21 of any license, permission, or authority conferred or to be
22 conferred under this code.

23 (d) A person may waive the immunity or privilege granted by
24 this section by executing, acknowledging, and filing with the
25 department a statement expressly waiving the immunity or privilege
26 for a specified transaction, matter, or thing. On filing the
27 statement:

28 (1) the testimony or documents produced by the person
29 in relation to the transaction, matter, or thing may be received by
30 or produced before a judge or justice or a court, grand jury, or
31 other tribunal; and

32 (2) the person is not entitled to immunity or
33 privilege for the testimony or documents received or produced under
34 Subdivision (1). (V.T.I.C. Art. 21.21, Sec. 12.)

1 Source Law

2 Sec. 12. If any person shall ask to be excused
3 from attending and testifying or from producing any
4 books, papers, records, correspondence or other
5 documents at any hearing on the ground that the
6 testimony or evidence required of him may tend to
7 incriminate him or subject him to a penalty or
8 forfeiture, and shall notwithstanding be directed to
9 give such testimony or produce such evidence, he must
10 nonetheless comply with such direction, but he shall
11 not thereafter be prosecuted or subjected to any
12 penalty or forfeiture for or on account of any
13 transaction, matter or thing concerning which he may
14 testify or produce evidence pursuant thereto, and no
15 testimony so given or evidence produced shall be
16 received against him upon any criminal action,
17 investigation or proceeding; provided, however, that
18 no such individual so testifying shall be exempt from
19 prosecution or punishment for any perjury committed by
20 him while so testifying and the testimony or evidence
21 so given or produced shall be admissible against him
22 upon any criminal action, investigation or proceeding
23 concerning such perjury, nor shall he be exempt from
24 the refusal, revocation or suspension of any license,
25 permission or authority conferred, or to be conferred,
26 pursuant to the Insurance Code of this state. Any such
27 individual may execute, acknowledge and file in the
28 office of the Board a statement expressly waiving such
29 immunity or privilege in respect to any transaction,
30 matter or thing specified in such statement and
31 thereupon the testimony of such person or such
32 evidence in relation to such transaction, matter or
33 thing may be received or produced before any judge or
34 justice, court, tribunal, grand jury or otherwise, and
35 if so received or produced such individual shall not be
36 entitled to any immunity or privilege on account of any
37 testimony he may so give or evidence so produced.

38 Revised Law

39 Sec. 541.008. LIBERAL CONSTRUCTION. This chapter shall be
40 liberally construed and applied to promote the underlying purposes
41 as provided by Section 541.001. (V.T.I.C. Art. 21.21, Sec. 1(b).)

42 Source Law

43 (b) This Article shall be liberally construed
44 and applied to promote its underlying purposes as set
45 forth in this section.

46 [Sections 541.009-541.050 reserved for expansion]

47 SUBCHAPTER B. UNFAIR METHODS OF COMPETITION AND UNFAIR OR
48 DECEPTIVE ACTS OR PRACTICES DEFINED

49 Revised Law

50 Sec. 541.051. MISREPRESENTATION REGARDING POLICY OR
51 INSURER. It is an unfair method of competition or an unfair or
52 deceptive act or practice in the business of insurance to:

1 (1) make, issue, or circulate or cause to be made,
2 issued, or circulated an estimate, illustration, circular, or
3 statement misrepresenting with respect to a policy issued or to be
4 issued:

5 (A) the terms of the policy;

6 (B) the benefits or advantages promised by the
7 policy; or

8 (C) the dividends or share of surplus to be
9 received on the policy;

10 (2) make a false or misleading statement regarding the
11 dividends or share of surplus previously paid on a similar policy;

12 (3) make a misleading representation or
13 misrepresentation regarding:

14 (A) the financial condition of an insurer; or

15 (B) the legal reserve system on which a life
16 insurer operates;

17 (4) use a name or title of a policy or class of
18 policies that misrepresents the true nature of the policy or class
19 of policies; or

20 (5) make a misrepresentation to a policyholder insured
21 by any insurer for the purpose of inducing or that tends to induce
22 the policyholder to allow an existing policy to lapse or to forfeit
23 or surrender the policy. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

24 Source Law

25 Sec. 4. The following are hereby defined as
26 unfair methods of competition and unfair and deceptive
27 acts or practices in the business of insurance:

28 (1) Misrepresentations and False
29 Advertising of Policy Contracts. Making, issuing,
30 circulating, or causing to be made, issued or
31 circulated, any estimate, illustration, circular or
32 statement misrepresenting the terms of any policy
33 issued or to be issued or the benefits or advantages
34 promised thereby or the dividends or share of the
35 surplus to be received thereon, or making any false or
36 misleading statements as to the dividends or share of
37 surplus previously paid on similar policies, or making
38 any misleading representation or any
39 misrepresentation as to the financial condition of any
40 insurer, or as to the legal reserve system upon which
41 any life insurer operates, or using any name or title
42 of any policy or class of policies misrepresenting the
43 true nature thereof, or making any misrepresentation

1 to any policyholder insured in any company for the
2 purpose of inducing or tending to induce such
3 policyholder to lapse, forfeit, or surrender his
4 insurance;

5 . . .

6 Revised Law

7 Sec. 541.052. FALSE INFORMATION AND ADVERTISING. (a) It
8 is an unfair method of competition or an unfair or deceptive act or
9 practice in the business of insurance to make, publish,
10 disseminate, circulate, or place before the public or directly or
11 indirectly cause to be made, published, disseminated, circulated,
12 or placed before the public an advertisement, announcement, or
13 statement containing an untrue, deceptive, or misleading
14 assertion, representation, or statement regarding the business of
15 insurance or a person in the conduct of the person's insurance
16 business.

17 (b) This section applies to an advertisement, announcement,
18 or statement made, published, disseminated, circulated, or placed
19 before the public:

20 (1) in a newspaper, magazine, or other publication;

21 (2) in a notice, circular, pamphlet, letter, or
22 poster;

23 (3) over a radio or television station; or

24 (4) in any other manner. (V.T.I.C. Art. 21.21, Sec. 4
25 (part).)

26 Source Law

27 Sec. 4. The following are hereby defined as
28 unfair methods of competition and unfair and deceptive
29 acts or practices in the business of insurance:

30 . . .
31 (2) False Information and Advertising
32 Generally. Making, publishing, disseminating,
33 circulating or placing before the public, or causing,
34 directly or indirectly, to be made, published,
35 disseminated, circulated, or placed before the public,
36 in a newspaper, magazine or other publication, or in
37 the form of a notice, circular, pamphlet, letter or
38 poster, or over any radio or television station, or in
39 any other way, an advertisement, announcement or
40 statement containing any assertion, representation or
41 statement with respect to the business of insurance or
42 with respect to any person in the conduct of his
43 insurance business, which is untrue, deceptive or
44 misleading;

45 . . .

1 Revised Law

2 Sec. 541.053. DEFAMATION OF INSURER. (a) It is an unfair
3 method of competition or an unfair or deceptive act or practice in
4 the business of insurance to directly or indirectly make, publish,
5 disseminate, or circulate or to aid, abet, or encourage the making,
6 publication, dissemination, or circulation of a statement that:

7 (1) is false, maliciously critical of, or derogatory
8 to the financial condition of an insurer; and

9 (2) is calculated to injure a person engaged in the
10 business of insurance.

11 (b) This section applies to any oral or written statement,
12 including a statement in any pamphlet, circular, article, or
13 literature. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

14 Source Law

15 Sec. 4. The following are hereby defined as
16 unfair methods of competition and unfair and deceptive
17 acts or practices in the business of insurance:

18 . . .
19 (3) Defamation. Making, publishing,
20 disseminating, or circulating, directly or
21 indirectly, or aiding, abetting or encouraging the
22 making, publishing, disseminating or circulating of
23 any oral or written statement or any pamphlet,
24 circular, article or literature which is false, or
25 maliciously critical of or derogatory to the financial
26 condition of any insurer, and which is calculated to
27 injure any person engaged in the business of
28 insurance;
29 . . .

30 Revised Law

31 Sec. 541.054. BOYCOTT, COERCION, OR INTIMIDATION. It is an
32 unfair method of competition or an unfair or deceptive act or
33 practice in the business of insurance to commit through concerted
34 action or to enter into an agreement to commit an act of boycott,
35 coercion, or intimidation that results in or tends to result in the
36 unreasonable restraint of or a monopoly in the business of
37 insurance. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

38 Source Law

39 Sec. 4. The following are hereby defined as
40 unfair methods of competition and unfair and deceptive
41 acts or practices in the business of insurance:

42 . . .
43 (4) Boycott, Coercion and Intimidation.

1 Entering into any agreement to commit, or by any
2 concerted action committing, any act of boycott,
3 coercion or intimidation resulting in or tending to
4 result in unreasonable restraint of, or monopoly in,
5 the business of insurance;
6 . . .

7 Revised Law

8 Sec. 541.055. FALSE FINANCIAL STATEMENT. (a) It is an
9 unfair method of competition or an unfair or deceptive act or
10 practice in the business of insurance to, with intent to deceive:

11 (1) file with a supervisory or other public official a
12 false statement of financial condition of an insurer; or

13 (2) make, publish, disseminate, circulate, deliver to
14 any person, or place before the public or directly or indirectly
15 cause to be made, published, disseminated, circulated, delivered to
16 any person, or placed before the public a false statement of
17 financial condition of an insurer.

18 (b) It is an unfair method of competition or an unfair or
19 deceptive act or practice in the business of insurance to make a
20 false entry in an insurer's book, report, or statement or wilfully
21 omit to make a true entry of a material fact relating to the
22 insurer's business in the insurer's book, report, or statement with
23 intent to deceive:

24 (1) an agent or examiner lawfully appointed to examine
25 the insurer's condition or affairs; or

26 (2) a public official to whom the insurer is required
27 by law to report or who has authority by law to examine the
28 insurer's condition or affairs. (V.T.I.C. Art. 21.21, Sec. 4
29 (part).)

30 Source Law

31 Sec. 4. The following are hereby defined as
32 unfair methods of competition and unfair and deceptive
33 acts or practices in the business of insurance:

34 . . .
35 (5) False Financial Statements. (a)
36 Filing with any supervisory or other public official,
37 or making, publishing, disseminating, circulating or
38 delivering to any person, or placing before the
39 public, or causing directly or indirectly, to be made,
40 published, disseminated, circulated, delivered to any
41 person, or placed before the public, any false
42 statement of financial condition of an insurer with
43 intent to deceive;

1 (b) Making any false entry in any
2 book, report or statement of any insurer with intent to
3 deceive any agent or examiner lawfully appointed to
4 examine into its condition or into any of its affairs,
5 or any public official to whom such insurer is required
6 by law to report, or who has authority by law to
7 examine into its condition or into any of its affairs,
8 or, with like intent, wilfully omitting to make a true
9 entry of any material fact pertaining to the business
10 of such insurer in any book, report or statement of
11 such insurer;
12 . . .

13 Revised Law

14 Sec. 541.056. PROHIBITED REBATES AND INDUCEMENTS. (a)
15 Subject to Section 541.058 and except as otherwise expressly
16 provided by law, it is an unfair method of competition or an unfair
17 or deceptive act or practice in the business of insurance to
18 knowingly permit the making of, offer to make, or make a life
19 insurance contract, life annuity contract, or accident and health
20 insurance contract or an agreement regarding the contract, other
21 than as plainly expressed in the issued contract, or directly or
22 indirectly pay, give, or allow or offer to pay, give, or allow as
23 inducement to enter into a life insurance contract, life annuity
24 contract, or accident and health insurance contract a rebate of
25 premiums payable on the contract, a special favor or advantage in
26 the dividends or other benefits of the contract, or a valuable
27 consideration or inducement not specified in the contract, or give,
28 sell, or purchase or offer to give, sell, or purchase in connection
29 with a life insurance, life annuity, or accident and health
30 insurance contract or as inducement to enter into the contract
31 stocks, bonds, or other securities of an insurer or other
32 corporation, association, or partnership, dividends or profits
33 accrued from the stocks, bonds, or securities, or anything of value
34 not specified in the contract.

35 (b) It is an unfair method of competition or an unfair or
36 deceptive act or practice in the business of insurance to issue or
37 deliver or to permit an agent, officer, or employee to issue or
38 deliver as an inducement to insurance:

39 (1) company stock or other capital stock;

40 (2) a benefit certificate or share in a corporation;

1 541.058, which lists certain practices that do not
2 constitute inducements under Section 4(8), V.T.I.C.
3 Article 21.21, revised in part as this section.

4 Revised Law

5 Sec. 541.057. UNFAIR DISCRIMINATION IN LIFE INSURANCE AND
6 ANNUITY CONTRACTS. Subject to Section 541.058, it is an unfair
7 method of competition or an unfair or deceptive act or practice in
8 the business of insurance to make or permit with respect to a life
9 insurance or life annuity contract an unfair discrimination between
10 individuals of the same class and equal life expectancy regarding:

- 11 (1) the rates charged;
12 (2) the dividends or other benefits payable; or
13 (3) any of the other terms and conditions of the
14 contract. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

15 Source Law

16 Sec. 4. The following are hereby defined as
17 unfair methods of competition and unfair and deceptive
18 acts or practices in the business of insurance:

19 . . .
20 (7) Unfair Discrimination. Making or
21 permitting any unfair discrimination between
22 individuals of the same class and equal expectation of
23 life in the rates charged for any contract of life
24 insurance or of life annuity or in the dividends or
25 other benefits payable thereon, or in any other of the
26 terms and conditions of such contract.

27 . . .

28 Revisor's Note

29 Section 4(7), V.T.I.C. Article 21.21, defines
30 certain discriminatory acts as unfair methods of
31 competition or unfair or deceptive acts or practices
32 in the business of insurance. The revised law adds a
33 reference to Section 541.058 for the reason stated in
34 the revisor's note to Section 541.056.

35 Revised Law

36 Sec. 541.058. CERTAIN PRACTICES NOT CONSIDERED
37 DISCRIMINATION OR INDUCEMENT. It is not a rebate or discrimination
38 prohibited by Section 541.056(a) or 541.057:

- 39 (1) for a life insurance or life annuity contract, to

1 pay a bonus to a policyholder or otherwise abate the policyholder's
2 premiums in whole or in part out of surplus accumulated from
3 nonparticipating insurance policies if the bonus or abatement:

4 (A) is fair and equitable to policyholders; and

5 (B) is in the best interests of the insurer and
6 its policyholders;

7 (2) for a life insurance policy issued on the
8 industrial debit plan, to make to a policyholder who has
9 continuously for a specified period made premium payments directly
10 to the insurer's office an allowance in an amount that fairly
11 represents the saving in collection expenses;

12 (3) for a group insurance policy, to readjust the rate
13 of premium based on the loss or expense experience under the policy
14 at the end of a policy year if the adjustment is retroactive for
15 only that policy year; or

16 (4) for a life annuity contract, to waive surrender
17 charges under the contract when the contract holder exchanges that
18 contract for another annuity contract issued by the same insurer if
19 the waiver and the exchange are fully, fairly, and accurately
20 explained to the contract holder in a manner that is not deceptive
21 or misleading. (V.T.I.C. Art. 21.21, Sec. 4 (part).)

22 Source Law

23 Sec. 4. . . .

24 (8) Rebates. . . .

25 (b) Nothing in clause 7 or paragraph
26 (a) of clause 8 of this subsection shall be construed
27 as including within the definition of discrimination
28 or rebates any of the following practices:

29 (i) in the case of any contract
30 of life insurance or life annuity, paying bonuses to
31 policyholders or otherwise abating their premiums in
32 whole or in part out of surplus accumulated from
33 non-participating insurance, provided that any such
34 bonuses or abatement of premiums shall be fair and
35 equitable to policyholders and for the best interests
36 of the company and its policyholders;

37 (ii) in the case of life
38 insurance policies issued on the industrial debit
39 plan, making allowance to policyholders who have
40 continuously for a specified period made premium
41 payments directly to an office of the insurer in an
42 amount which fairly represents the saving in
43 collection expenses;

44 (iii) readjustment of the rate
45 of premium for a group insurance policy based on the

1 loss or expense experience thereunder, at the end of
2 the first or any subsequent policy year of insurance
3 thereunder, which may be made retroactive only for
4 such policy year; or

5 (iv) in the case of a life
6 annuity, waiving surrender charges under an annuity
7 contract when the contract holder exchanges the
8 annuity contract for another annuity contract issued
9 by the same insurer, if the waiver and the exchange are
10 fully, fairly, and accurately explained to the
11 contract holder in a manner that is not deceptive or
12 misleading.

13 . . .

14 Revisor's Note

15 Section 4(8)(b)(iii), V.T.I.C. Article 21.21,
16 refers to "the first or any subsequent policy year of
17 insurance thereunder" of certain insurance policies.
18 The revised law substitutes a reference to "a policy
19 year" for the quoted language because the first or a
20 subsequent policy year necessarily means any policy
21 year.

22 Revised Law

23 Sec. 541.059. DECEPTIVE NAME, WORD, SYMBOL, DEVICE, OR
24 SLOGAN. (a) Except as provided by Subsection (b), it is an unfair
25 method of competition or an unfair or deceptive act or practice in
26 the business of insurance to use, display, publish, circulate,
27 distribute, or cause to be used, displayed, published, circulated,
28 or distributed in a letter, pamphlet, circular, contract, policy,
29 evidence of coverage, article, poster, or other document,
30 literature, or public media:

31 (1) a name as the corporate or business name of a
32 person or entity engaged in the business of insurance or in an
33 insurance-related business in this state that is the same as or
34 deceptively similar to the name adopted and used by an insurance
35 entity, health maintenance organization, third-party
36 administrator, or group hospital service corporation authorized to
37 engage in business under the laws of this state; or

38 (2) a word, symbol, device, or slogan, either alone or
39 in combination and regardless of whether registered, and including
40 the titles, designations, character names, and distinctive

1 features of broadcast or other advertising, that is the same as or
2 deceptively similar to a word, symbol, device, or slogan adopted
3 and used by an insurance entity, health maintenance organization,
4 third-party administrator, or group hospital service corporation
5 to distinguish the entity or the entity's products or services from
6 another entity.

7 (b) If more than one person or entity uses names, words,
8 symbols, devices, or slogans, either alone or in combination, that
9 are the same or deceptively similar and are likely to cause
10 confusion or mistake, the person or entity that demonstrates the
11 first continuous actual use of the name, word, symbol, device,
12 slogan, or combination has not engaged in an unfair method of
13 competition or deceptive act or practice under this section.
14 (V.T.I.C. Art. 21.21, Sec. 4 (part).)

15 Source Law

16 Sec. 4. The following are hereby defined as
17 unfair methods of competition and unfair and deceptive
18 acts or practices in the business of insurance:

19 . . .
20 (9) Deceptive Name, Word, Symbol, Device,
21 or Slogan. Using, displaying, publishing,
22 circulating, distributing, or causing to be used,
23 displayed, published, circulated, or distributed in
24 any letter, pamphlet, circular, contract, policy,
25 evidence of coverage, article, poster, or other
26 document, literature, or public media of:

27 (a) a name as the corporate or
28 business name of a person or entity engaged in an
29 insurance or insurance related business in this state
30 that is the same as, or deceptively similar to, the
31 name adopted and used by an insurance entity, health
32 maintenance organization, third party administrator,
33 or group hospital service company authorized to do
34 business under the laws of this state; or

35 (b) a word, symbol, device, slogan,
36 or any combination of these items, whether registered
37 or not registered, that is the same as or deceptively
38 similar to one adopted and used by an insurance entity,
39 health maintenance organization, third party
40 administrator, or group hospital service company to
41 distinguish such entities, products, or service from
42 other entities, and includes the title, designation,
43 character names, and distinctive features of broadcast
44 or other advertising.

45 Where two persons or entities are using a name,
46 word, symbol, device, slogan, or any combination of
47 these items that are the same or deceptively similar
48 and are likely to cause confusion or a mistake, the
49 user who can demonstrate the first continuous actual
50 use of such name, word, symbol, device, slogan, or
51 combination of these items shall not have committed an
52 unfair method of competition or deceptive act or

1 practice.

2 . . .

3 Revised Law

4 Sec. 541.060. UNFAIR SETTLEMENT PRACTICES. (a) It is an
5 unfair method of competition or an unfair or deceptive act or
6 practice in the business of insurance to engage in the following
7 unfair settlement practices with respect to a claim by an insured or
8 beneficiary:

9 (1) misrepresenting to a claimant a material fact or
10 policy provision relating to coverage at issue;

11 (2) failing to attempt in good faith to effectuate a
12 prompt, fair, and equitable settlement of:

13 (A) a claim with respect to which the insurer's
14 liability has become reasonably clear; or

15 (B) a claim under one portion of a policy with
16 respect to which the insurer's liability has become reasonably
17 clear to influence the claimant to settle another claim under
18 another portion of the coverage unless payment under one portion of
19 the coverage constitutes evidence of liability under another
20 portion;

21 (3) failing to promptly provide to a policyholder a
22 reasonable explanation of the basis in the policy, in relation to
23 the facts or applicable law, for the insurer's denial of a claim or
24 offer of a compromise settlement of a claim;

25 (4) failing within a reasonable time to:

26 (A) affirm or deny coverage of a claim to a
27 policyholder; or

28 (B) submit a reservation of rights to a
29 policyholder;

30 (5) refusing, failing, or unreasonably delaying a
31 settlement offer under applicable first-party coverage on the basis
32 that other coverage may be available or that third parties are
33 responsible for the damages suffered, except as may be specifically
34 provided in the policy;

35 (6) undertaking to enforce a full and final release of

1 a claim from a policyholder when only a partial payment has been
2 made, unless the payment is a compromise settlement of a doubtful or
3 disputed claim;

4 (7) refusing to pay a claim without conducting a
5 reasonable investigation with respect to the claim;

6 (8) with respect to a Texas personal automobile
7 insurance policy, delaying or refusing settlement of a claim solely
8 because there is other insurance of a different kind available to
9 satisfy all or part of the loss forming the basis of that claim; or

10 (9) requiring a claimant as a condition of settling a
11 claim to produce the claimant's federal income tax returns for
12 examination or investigation by the person unless:

13 (A) a court orders the claimant to produce those
14 tax returns;

15 (B) the claim involves a fire loss; or

16 (C) the claim involves lost profits or income.

17 (b) Subsection (a) does not provide a cause of action to a
18 third party asserting one or more claims against an insured covered
19 under a liability insurance policy. (V.T.I.C. Art. 21.21, Sec. 4
20 (part).)

21 Source Law

22 Sec. 4. The following are hereby defined as
23 unfair methods of competition and unfair and deceptive
24 acts or practices in the business of insurance:

25 . . .
26 (10) Unfair Settlement Practices. (a)
27 Engaging in any of the following unfair settlement
28 practices with respect to a claim by an insured or
29 beneficiary:

30 (i) misrepresenting to a
31 claimant a material fact or policy provision relating
32 to coverage at issue;

33 (ii) failing to attempt in good
34 faith to effectuate a prompt, fair, and equitable
35 settlement of a claim with respect to which the
36 insurer's liability has become reasonably clear;

37 (iii) failing to attempt, in
38 good faith, to effectuate a prompt, fair, and
39 equitable settlement under one portion of a policy of a
40 claim with respect to which the insurer's liability has
41 become reasonably clear in order to influence the
42 claimant to settle an additional claim under another
43 portion of the coverage, provided that this
44 prohibition does not apply if payment under one
45 portion of the coverage constitutes evidence of
46 liability under another portion of the policy;

1 (iv) failing to provide
2 promptly to a policyholder a reasonable explanation of
3 the basis in the policy, in relation to the facts or
4 applicable law, for the insurer's denial of a claim or
5 for the offer of a compromise settlement of a claim;

6 (v) failing within a reasonable
7 time to:

8 (A) affirm or deny
9 coverage of a claim to a policyholder; or

10 (B) submit a reservation
11 of rights to a policyholder;

12 (vi) refusing, failing, or
13 unreasonably delaying an offer of settlement under
14 applicable first-party coverage on the basis that
15 other coverage may be available or that third parties
16 are responsible for the damages suffered, except as
17 may be specifically provided in the policy;

18 (vii) undertaking to enforce a
19 full and final release of a claim from a policyholder
20 when only a partial payment has been made, provided
21 that this prohibition does not apply to a compromise
22 settlement of a doubtful or disputed claim;

23 (viii) refusing to pay a claim
24 without conducting a reasonable investigation with
25 respect to the claim;

26 (ix) with respect to a Texas
27 personal auto policy, delaying or refusing settlement
28 of a claim solely because there is other insurance of a
29 different type available to satisfy all or any part of
30 the loss forming the basis of that claim; or

31 (x) requiring a claimant, as a
32 condition of settling a claim, to produce the
33 claimant's federal income tax returns for examination
34 or investigation by the person unless:

35 (A) the claimant is
36 ordered to produce those tax returns by a court;

37 (B) the claim involves a
38 fire loss; or

39 (C) the claim involves
40 lost profits or income.

41 (b) Paragraph (a) of this clause does
42 not provide a cause of action to a third party
43 asserting one or more claims against an insured
44 covered under a liability insurance policy.

45 . . .

46 Revised Law

47 Sec. 541.061. MISREPRESENTATION OF INSURANCE POLICY. It
48 is an unfair method of competition or an unfair or deceptive act or
49 practice in the business of insurance to misrepresent an insurance
50 policy by:

51 (1) making an untrue statement of material fact;

52 (2) failing to state a material fact necessary to make
53 other statements made not misleading, considering the
54 circumstances under which the statements were made;

55 (3) making a statement in a manner that would mislead a
56 reasonably prudent person to a false conclusion of a material fact;

- 1 (4) making a material misstatement of law; or
2 (5) failing to disclose a matter required by law to be
3 disclosed, including failing to make a disclosure in accordance
4 with another provision of this code. (V.T.I.C. Art. 21.21, Sec. 4
5 (part).)

6 Source Law

7 Sec. 4. The following are hereby defined as
8 unfair methods of competition and unfair and deceptive
9 acts or practices in the business of insurance:

10 (11) Misrepresentation of Insurance
11 Policy. Misrepresenting an insurance policy by:

12 (a) making an untrue statement of
13 material fact;

14 (b) failing to state a material fact
15 that is necessary to make other statements made not
16 misleading, considering the circumstances under which
17 the statements were made;

18 (c) making a statement in such manner
19 as to mislead a reasonably prudent person to a false
20 conclusion of a material fact;

21 (d) making a material misstatement of
22 law; or

23 (e) failing to disclose any matter
24 required by law to be disclosed, including a failure to
25 make disclosure in accordance with another provision
26 of this code.
27

28 [Sections 541.062-541.100 reserved for expansion]

29 SUBCHAPTER C. DETERMINATION OF UNFAIR METHODS OF COMPETITION AND
30 UNFAIR OR DECEPTIVE ACTS OR PRACTICES; SANCTIONS AND PENALTIES

31 Revised Law

32 Sec. 541.101. EXAMINATION AND INVESTIGATION. The
33 department may examine and investigate the affairs of a person
34 engaged in the business of insurance in this state to determine
35 whether the person has or is engaged in an unfair method of
36 competition or unfair or deceptive act or practice prohibited by
37 Section 541.003. (V.T.I.C. Art. 21.21, Sec. 5.)

38 Source Law

39 Sec. 5. The Board shall have power to examine
40 and investigate into the affairs of every person
41 engaged in the business of insurance in this state in
42 order to determine whether such person has been or is
43 engaged in any unfair method of competition or in any
44 unfair or deceptive act or practice prohibited by
45 Section 3 of this Act.

46 Revised Law

47 Sec. 541.102. STATEMENT OF CHARGES; NOTICE OF HEARING. (a)

1 When the department has reason to believe that a person engaged in
2 the business of insurance in this state has engaged or is engaging
3 in this state in an unfair method of competition or unfair or
4 deceptive act or practice defined by Subchapter B and that a
5 proceeding by the department regarding the charges is in the
6 interest of the public, the department shall issue and serve on the
7 person:

- 8 (1) a statement of the charges; and
- 9 (2) a notice of the hearing on the charges, including
10 the time and place for the hearing.

11 (b) The department may not hold the hearing before the sixth
12 day after the date the notice is served. (V.T.I.C. Art. 21.21, Sec.
13 6(a).)

14 Source Law

15 Sec. 6. (a) Whenever the Board shall have
16 reason to believe that any such person has been engaged
17 or is engaging in this state in any unfair method of
18 competition or any unfair or deceptive act or practice
19 defined in Section 4, and that a proceeding by it in
20 respect thereto would be to the interest of the public,
21 it shall issue and serve upon such person a statement
22 of the charges in that respect and a notice of a
23 hearing thereon to be held at a time and place fixed in
24 the notice, which shall not be less than five days
25 after the date of the service thereof;

26 Revised Law

27 Sec. 541.103. HEARING. A person against whom charges are
28 made under Section 541.102 is entitled at the hearing on the charges
29 to have an opportunity to be heard and show cause why the department
30 should not issue an order requiring the person to cease and desist
31 from the unfair method of competition or unfair or deceptive act or
32 practice described in the charges. (V.T.I.C. Art. 21.21, Sec. 6(b)
33 (part).)

34 Source Law

35 (b) At the time and place fixed for such
36 hearing, such person shall have an opportunity to be
37 heard and to show cause why an order should not be made
38 by the Board requiring such person to cease and desist
39 from the acts, methods or practices so complained
40 of. . . .

1 Revised Law

2 Sec. 541.104. HEARING PROCEDURES. (a) Nothing in this
3 chapter requires the observance of formal rules of pleading or
4 evidence at a hearing under this subchapter.

5 (b) At a hearing under this subchapter, the department, on a
6 showing of good cause, shall permit any person to intervene,
7 appear, and be heard by counsel or in person. (V.T.I.C. Art. 21.21,
8 Secs. 6(b) (part), (c).)

9 Source Law

10 (b) . . . Upon good cause shown, the Board
11 shall permit any person to intervene, appear and be
12 heard at such hearing by counsel or in person;

13 (c) Nothing contained in this Act shall require
14 the observance at any such hearing of formal rules of
15 pleading or evidence;

16 Revisor's Note

17 Section 6(d), V.T.I.C. Article 21.21, authorizes
18 the State Board of Insurance, the functions of which
19 were transferred to the commissioner of insurance and
20 the Texas Department of Insurance, to use certain
21 procedures in conducting a hearing, including issuing
22 a subpoena. The revised law omits that provision
23 because it duplicates Section 36.152 of this code. The
24 omitted language reads:

25 (d) The Board, upon such hearing, may
26 administer oaths, examine and cross-examine
27 witnesses, receive oral and documentary
28 evidence, and shall have the power to
29 subpoena witnesses, compel their
30 attendance, and require the production of
31 books, papers, records, correspondence, or
32 other documents which it deems relevant to
33 the inquiry. . . .

34 Revised Law

35 Sec. 541.105. RECORD OF HEARING. (a) At a hearing under
36 this subchapter, the department may, and at the request of a party
37 to the hearing shall, make a stenographic record of the proceedings
38 and the evidence presented at the hearing.

39 (b) If the department does not make a stenographic record
40 and a person seeks judicial review of the decision made at the

1 hearing, the department shall prepare a statement of the evidence
2 and proceeding for use on review. (V.T.I.C. Art. 21.21, Sec. 6(d)
3 (part).)

4 Source Law

5 (d) . . . The Board, upon such hearing, may,
6 and upon the request of any party, shall cause to be
7 made a stenographic record of all the evidence and all
8 the proceedings had at such hearing. If no
9 stenographic record is made and if a judicial review is
10 sought, the Board shall prepare a statement of the
11 evidence and proceeding for use on review. . . .

12 Revised Law

13 Sec. 541.106. COMPLIANCE WITH SUBPOENA. (a) If a person
14 refuses to comply with a subpoena issued in connection with a
15 hearing under this subchapter or refuses to testify with respect to
16 a matter about which the person may be lawfully interrogated, on
17 application of the department, a district court in Travis County or
18 in the county in which the person resides may order the person to
19 comply with the subpoena or testify.

20 (b) A court may punish as contempt a person's failure to
21 obey an order under this section. (V.T.I.C. Art. 21.21, Sec. 6(d)
22 (part).)

23 Source Law

24 (d) . . . In case of a refusal of any person to
25 comply with any subpoena issued hereunder or to
26 testify with respect to any matter concerning which he
27 may be lawfully interrogated, the District Court of
28 Travis County or the county where such party resides,
29 on application of the Board, may issue an order
30 requiring such person to comply with such subpoena and
31 to testify; and any failure to obey any such order of
32 the court may be punished by the court as a contempt
33 thereof.

34 Revised Law

35 Sec. 541.107. DETERMINATION OF VIOLATION. After a hearing
36 under this subchapter, the department shall determine whether:

37 (1) the method of competition or the act or practice
38 considered in the hearing is defined as:

39 (A) an unfair method of competition or deceptive
40 act or practice under Subchapter B or a rule adopted under this
41 chapter; or

1 (B) a false, misleading, or deceptive act or
2 practice under Section 17.46, Business & Commerce Code; and

3 (2) the person against whom the charges were made
4 engaged in the method of competition or act or practice in violation
5 of:

6 (A) this chapter or a rule adopted under this
7 chapter; or

8 (B) Subchapter E, Chapter 17, Business & Commerce
9 Code, as specified in Section 17.46, Business & Commerce Code.
10 (V.T.I.C. Art. 21.21, Sec. 7(a) (part).)

11 Source Law

12 Sec. 7. (a) If, after such hearing under the
13 terms of Section 6 of the Act, the Board shall
14 determine that the method of competition or the act or
15 practice in question is defined in Section 4 of this
16 Article, or rules or regulations issued under this
17 Article, or in Section 17.46 of the Business &
18 Commerce Code, as amended, and that the person
19 complained of has engaged in such method of
20 competition, act or practice in violation of this
21 Article or rules and regulations issued under this
22 Article or of the Deceptive Trade Practices--Consumer
23 Protection Act (Sections 17.41 et seq., Business &
24 Commerce Code), as specified in Section 17.46 of the
25 Business & Commerce Code

26 Revisor's Note

27 Section 7(a), V.T.I.C. Article 21.21, refers to
28 Section 17.46, Business & Commerce Code, "as amended."
29 Throughout this chapter, the revised law omits
30 references to "as amended" and other similar language
31 with respect to a state statute because under Section
32 311.027, Government Code (Code Construction Act),
33 applicable to the revised law, a reference to a statute
34 includes reenactments, revisions, or amendments of the
35 statute.

36 Revised Law

37 Sec. 541.108. CEASE AND DESIST ORDER. On determining that
38 a person committed a violation described by Section 541.107, the
39 department shall:

40 (1) make written findings; and

1 (2) issue and serve on the person an order requiring
2 the person to cease and desist from engaging in the method of
3 competition or act or practice determined to be a violation.
4 (V.T.I.C. Art. 21.21, Sec. 7(a) (part).)

5 Source Law

6 (a) . . . it shall reduce its findings to
7 writing and issue and cause to be served upon the
8 person charged with the violation an order requiring
9 such person to cease and desist from engaging in such
10 method of competition, act or practice.

11 Revised Law

12 Sec. 541.109. MODIFICATION OR SETTING ASIDE OF ORDER. On
13 the notice and in the manner the department determines proper, the
14 department may modify or set aside in whole or in part a cease and
15 desist order issued under Section 541.108 at any time before a
16 petition appealing the order is filed in accordance with Subchapter
17 D, Chapter 36. (V.T.I.C. Art. 21.21, Sec. 7(b).)

18 Source Law

19 (b) Until a petition appealing from such order
20 shall have been filed in a District Court of Travis
21 County, Texas, in accordance with Subchapter F of
22 Chapter 21 of the Insurance Code of this state, or any
23 amendment thereof, the Board may at any time, upon such
24 notice and in such manner as it shall deem proper,
25 modify or set aside in whole or in part any order
26 issued under this section.

27 Revisor's Note

28 (1) Section 7(b), V.T.I.C. Article 21.21,
29 refers to filing an appeal of a cease and desist order
30 "in a District Court of Travis County, Texas." The
31 revised law omits the quoted language because it
32 duplicates the requirement in Section 36.202(b) of
33 this code that a petition for judicial review of an
34 action of the commissioner of insurance be filed in a
35 district court in Travis County.

36 (2) Section 7(b), V.T.I.C. Article 21.21,
37 refers to the filing of an appeal of a cease and desist
38 order "in accordance with Subchapter F of Chapter 21 of
39 the Insurance Code of this state." That subchapter

1 consisted of V.T.I.C. Article 21.80, which provided
2 for judicial review of actions of the State Board of
3 Insurance. Chapter 242, Acts of the 72nd Legislature,
4 Regular Session, 1991, repealed V.T.I.C. Article 21.80
5 and amended V.T.I.C. Article 1.04 to include judicial
6 review provisions in that article. V.T.I.C. Article
7 1.04 was codified in 1999 as Subchapter D, Chapter 36,
8 of this code, and the revised law is drafted
9 accordingly.

10 Revised Law

11 Sec. 541.110. ADMINISTRATIVE PENALTY. (a) A person who
12 violates a cease and desist order issued under Section 541.108 is
13 subject to an administrative penalty under Chapter 84.

14 (b) In determining whether a person has violated a cease and
15 desist order, the department shall consider the maintenance of
16 procedures reasonably adapted to ensure compliance with the order.

17 (c) An administrative penalty imposed under this section
18 may not exceed:

19 (1) \$1,000 for each violation; or

20 (2) \$5,000 for all violations.

21 (d) An order of the department imposing an administrative
22 penalty under this section applies only to a violation of the cease
23 and desist order committed before the date the order imposing the
24 penalty is issued. (V.T.I.C. Art. 21.21, Secs. 7(c), (d).)

25 Source Law

26 (c) Any person who violates the terms of a cease
27 and desist order under this section is subject to an
28 administrative penalty under Article 1.10E of this
29 code. An administrative penalty assessed under this
30 subsection may not exceed \$1,000 for each violation
31 and a total of \$5,000 for all violations. In
32 determining whether or not a cease and desist order has
33 been violated, the Board shall take into consideration
34 the maintenance of procedures reasonably adapted to
35 insure compliance with the order.

36 (d) An order of the Board awarding an
37 administrative penalty under Subsection (c) of this
38 section applies only to violations of this order
39 incurred prior to the awarding of the penalty order.

1 Revised Law

2 Sec. 541.111. CIVIL PENALTY FOR VIOLATION OF CEASE AND
3 DESIST ORDER. (a) A person who is found by a court to have
4 violated a cease and desist order issued under Section 541.108 is
5 liable to the state for a penalty. The state may recover the
6 penalty in a civil action.

7 (b) The penalty may not exceed \$50 unless the court finds
8 the violation to be wilful, in which case the penalty may not exceed
9 \$500. (V.T.I.C. Art. 21.21, Sec. 10.)

10 Source Law

11 Sec. 10. Any person who violates a cease and
12 desist order of the Board under Section 7, while such
13 order is in effect, shall, upon proof thereof to the
14 satisfaction of the court, forfeit and pay to the State
15 of Texas a sum not to exceed Fifty Dollars (\$50.00),
16 which may be recovered in a civil action, except that
17 if such violation is found to be willful, the amount of
18 such penalty shall be a sum not to exceed Five Hundred
19 Dollars (\$500.00).

20 Revisor's Note

21 (1) Section 10, V.T.I.C. Article 21.21, refers
22 to a person who violates a cease and desist order
23 "while such order is in effect." The revised law omits
24 the quoted phrase as unnecessary because a person
25 cannot violate an order that is not in effect.

26 (2) Section 10, V.T.I.C. Article 21.21, refers
27 to a person who violates a cease and desist order and
28 provides that "upon proof thereof to the satisfaction
29 of the court" the person is liable to the state for a
30 penalty. The revised law omits the quoted language
31 because the procedures for establishing proof in a
32 court proceeding are established under other law and
33 it is not necessary to state in this provision that the
34 proof must be satisfactory.

35 [Sections 541.112-541.150 reserved for expansion]

36 SUBCHAPTER D. PRIVATE ACTION FOR DAMAGES

37 Revised Law

38 Sec. 541.151. PRIVATE ACTION FOR DAMAGES AUTHORIZED. A

1 person who sustains actual damages may bring an action against
2 another person for those damages caused by the other person
3 engaging in an act or practice:

4 (1) defined by Subchapter B to be an unfair method of
5 competition or an unfair or deceptive act or practice in the
6 business of insurance; or

7 (2) specifically enumerated in Section 17.46(b),
8 Business & Commerce Code, as an unlawful deceptive trade practice
9 if the person bringing the action shows that the person relied on
10 the act or practice to the person's detriment. (V.T.I.C.
11 Art. 21.21, Sec. 16(a).)

12 Source Law

13 Sec. 16. (a) Any person who has sustained
14 actual damages caused by another's engaging in an act
15 or practice declared in Section 4 of this Article to be
16 unfair methods of competition or unfair or deceptive
17 acts or practices in the business of insurance or in
18 any practice specifically enumerated in a subdivision
19 of Section 17.46(b), Business & Commerce Code, as an
20 unlawful deceptive trade practice may maintain an
21 action against the person or persons engaging in such
22 acts or practices. To maintain an action for a
23 deceptive act or practice enumerated in Section
24 17.46(b), Business & Commerce Code, a person must show
25 that the person has relied on the act or practice to
26 the person's detriment.

27 Revised Law

28 Sec. 541.152. DAMAGES, ATTORNEY'S FEES, AND OTHER RELIEF.

29 (a) A plaintiff who prevails in an action under this subchapter may
30 obtain:

31 (1) the amount of actual damages, plus court costs and
32 reasonable and necessary attorney's fees;

33 (2) an order enjoining the act or failure to act
34 complained of; or

35 (3) any other relief the court determines is proper.

36 (b) On a finding by the trier of fact that the defendant
37 knowingly committed the act complained of, the trier of fact may
38 award an amount not to exceed three times the amount of actual
39 damages. (V.T.I.C. Art. 21.21, Sec. 16(b).)

1 Source Law

2 (b) In a suit filed under this section, any
3 plaintiff who prevails may obtain:

4 (1) the amount of actual damages plus
5 court costs and reasonable and necessary attorneys'
6 fees. If the trier of fact finds that the defendant
7 knowingly committed the acts complained of, the trier
8 of fact may award not more than three times the amount
9 of actual damages; or

10 (2) an order enjoining such acts or
11 failure to act; or

12 (3) any other relief which the court deems
13 proper.

14 Revised Law

15 Sec. 541.153. FRIVOLOUS ACTION. A court shall award to the
16 defendant court costs and reasonable and necessary attorney's fees
17 if the court finds that an action under this subchapter is
18 groundless and brought in bad faith or brought for the purpose of
19 harassment. (V.T.I.C. Art. 21.21, Sec. 16(c).)

20 Source Law

21 (c) On a finding by the court that an action
22 under this section was groundless and brought in bad
23 faith or brought for the purpose of harassment, the
24 court shall award to the defendant reasonable and
25 necessary attorneys' fees and court costs.

26 Revised Law

27 Sec. 541.154. PRIOR NOTICE OF ACTION. (a) A person
28 seeking damages in an action against another person under this
29 subchapter must provide written notice to the other person not
30 later than the 61st day before the date the action is filed.

31 (b) The notice must advise the other person of:

32 (1) the specific complaint; and

33 (2) the amount of actual damages and expenses,
34 including attorney's fees reasonably incurred in asserting the
35 claim against the other person.

36 (c) The notice is not required if giving notice is
37 impracticable because the action:

38 (1) must be filed to prevent the statute of
39 limitations from expiring; or

40 (2) is asserted as a counterclaim. (V.T.I.C.
41 Art. 21.21, Secs. 16(e), (f).)

1 Source Law

2 (e) As a prerequisite to filing a suit seeking
3 damages under this section against any person, the
4 person seeking damages shall give written notice to
5 the other person at least 60 days before filing suit.
6 The notice must advise the person of the specific
7 complaint and the amount of actual damages and
8 expenses, including any attorneys' fees reasonably
9 incurred in asserting the claim against the defendant.

10 (f) If giving 60 days' written notice is
11 impracticable because the suit must be filed in order
12 to prevent the expiration of the statute of
13 limitations or because the claim is asserted as a
14 counterclaim, the notice provided for in Subsection
15 (e) of this section is not required.

16 Revised Law

17 Sec. 541.155. ABATEMENT. (a) A person against whom an
18 action under this subchapter is pending who does not receive the
19 notice as required by Section 541.154 may file a plea in abatement
20 not later than the 30th day after the date the person files an
21 original answer in the court in which the action is pending.

22 (b) The court shall abate the action if, after a hearing,
23 the court finds that the person is entitled to an abatement because
24 the claimant did not provide the notice as required by Section
25 541.154.

26 (c) An action is automatically abated without a court order
27 beginning on the 11th day after the date a plea in abatement is
28 filed if the plea:

29 (1) is verified and alleges that the person against
30 whom the action is pending did not receive the notice as required by
31 Section 541.154; and

32 (2) is not controverted by an affidavit filed by the
33 claimant before the 11th day after the date the plea in abatement is
34 filed.

35 (d) An abatement under this section continues until the 60th
36 day after the date notice is provided in compliance with Section
37 541.154.

38 (e) This section does not apply if Section 541.154(c)
39 applies. (V.T.I.C. Art. 21.21, Secs. 16(g), (h), (i).)

40 Source Law

41 (g) A person against whom a suit is pending who

1 does not receive written notice, as required by
2 Subsection (e) of this section, may file a plea in
3 abatement not later than the 30th day after the date
4 the person files an original answer in the court in
5 which the suit is pending. This subsection does not
6 apply if Subsection (f) of this section applies.

7 (h) The court shall abate the suit if the court,
8 after a hearing, finds that the person is entitled to
9 an abatement because notice was not provided as
10 required by this section. A suit is automatically
11 abated without the order of the court beginning on the
12 11th day after the date a plea in abatement is filed
13 under Subsection (g) if the plea in abatement:

14 (1) is verified and alleges that the
15 person against whom the suit is pending did not receive
16 the written notice as required by Subsection (e); and

17 (2) is not controverted by an affidavit
18 filed by the claimant before the 11th day after the
19 date on which the plea in abatement is filed.

20 (i) An abatement under Subsection (h) continues
21 until the 60th day after the date that written notice
22 is served in compliance with Subsection (e).

23 Revised Law

24 Sec. 541.156. SETTLEMENT OFFER. (a) A person who
25 receives notice provided under Section 541.154 may make a
26 settlement offer during a period beginning on the date notice under
27 Section 541.154 is received and ending on the 60th day after that
28 date.

29 (b) In addition to the period described by Subsection (a),
30 the person may make a settlement offer during a period:

31 (1) if mediation is not conducted under Section
32 541.161, beginning on the date an original answer is filed in the
33 action and ending on the 90th day after that date; or

34 (2) if mediation is conducted under Section 541.161,
35 beginning on the day after the date the mediation ends and ending on
36 the 20th day after that date. (V.T.I.C. Art. 21.21, Secs. 16A(a),
37 (b), (c).)

38 Source Law

39 Sec. 16A. (a) A person who receives notice
40 under Section 16(e) of this article may tender an offer
41 of settlement at any time during the period beginning
42 on the date notice is received and ending on the 60th
43 day after that date.

44 (b) If a mediation under Section 16B of this
45 article is not conducted, the person may tender an
46 offer of settlement at any time during the period
47 beginning on the date an original answer is filed and
48 ending on the 90th day after that date.

49 (c) If a mediation under Section 16B of this
50 article is conducted, a person against whom a claim
51 under Section 16 of this article is pending may tender

1 an offer of settlement during the period beginning on
2 the day after the date that the mediation ends and
3 ending on the 20th day after that date.

4 Revised Law

5 Sec. 541.157. CONTENTS OF SETTLEMENT OFFER. A settlement
6 offer made by a person against whom a claim under this subchapter is
7 pending must include an offer to pay the following amounts,
8 separately stated:

9 (1) an amount of money or other consideration, reduced
10 to its cash value, as settlement of the claim for damages; and

11 (2) an amount of money to compensate the claimant for
12 the claimant's reasonable and necessary attorney's fees incurred as
13 of the date of the offer. (V.T.I.C. Art. 21.21, Sec. 16A(d).)

14 Source Law

15 (d) An offer of settlement tendered by a person
16 against whom a claim under Section 16 of this article
17 is pending must include an offer to pay the following
18 amounts of money, separately stated:

19 (1) an amount of money or other
20 consideration, reduced to its cash value, as
21 settlement of the claim for damages; and

22 (2) an amount of money to compensate the
23 claimant for the claimant's reasonable and necessary
24 attorneys' fees incurred as of the date of the offer.

25 Revised Law

26 Sec. 541.158. REJECTION OF SETTLEMENT OFFER. (a) A
27 settlement offer is rejected unless both parts of the offer
28 required under Section 541.157 are accepted by the claimant not
29 later than the 30th day after the date the offer is made.

30 (b) A settlement offer made by a person against whom a claim
31 under this subchapter is pending that complies with this subchapter
32 and is rejected by the claimant may be filed with the court
33 accompanied by an affidavit certifying the offer's rejection.
34 (V.T.I.C. Art. 21.21, Secs. 16A(e), (f).)

35 Source Law

36 (e) Unless both parts of an offer of settlement
37 required under Subsection (d) of this section are
38 accepted by the claimant not later than the 30th day
39 after the date the offer is made, the offer is
40 rejected.

41 (f) A settlement offer tendered by a person
42 against whom a claim under Section 16 of this article
43 is pending that complies with this section and that has
44 been rejected by the claimant may be filed with the

1 court with an affidavit certifying its rejection.

2 Revised Law

3 Sec. 541.159. LIMIT ON RECOVERY AFTER SETTLEMENT OFFER.

4 (a) If the court finds that the amount stated in the settlement
5 offer for damages under Section 541.157(1) is the same as,
6 substantially the same as, or more than the amount of damages found
7 by the trier of fact, the claimant may not recover as damages any
8 amount in excess of the lesser of:

9 (1) the amount of damages stated in the offer; or

10 (2) the amount of damages found by the trier of fact.

11 (b) If the court makes the finding described by Subsection
12 (a), the court shall determine reasonable and necessary attorney's
13 fees to compensate the claimant for attorney's fees incurred before
14 the date and time the rejected settlement offer was made. If the
15 court finds that the amount stated in the offer for attorney's fees
16 under Section 541.157(2) is the same as, substantially the same as,
17 or more than the amount of reasonable and necessary attorney's fees
18 incurred by the claimant as of the date of the offer, the claimant
19 may not recover any amount of attorney's fees in excess of the
20 amount of fees stated in the offer.

21 (c) This section does not apply if the court finds that the
22 offering party:

23 (1) could not perform the offer at the time the offer
24 was made; or

25 (2) substantially misrepresented the cash value of the
26 offer.

27 (d) The court shall award:

28 (1) damages as required by Section 541.152 if
29 Subsection (a) does not apply; and

30 (2) attorney's fees as required by Section 541.152 if
31 Subsection (b) does not apply. (V.T.I.C. Art. 21.21, Secs. 16A(g),
32 (h), (i), (j).)

33 Source Law

34 (g) If the court finds that the amount tendered
35 in the settlement offer for damages under Subsection

1 (d)(1) of this section is the same as, substantially
2 the same as, or more than the damages found by the
3 trier of fact, the claimant may not recover as damages
4 any amount in excess of the lesser of:

5 (1) the amount of damages tendered in the
6 settlement offer; or

7 (2) the amount of damages found by the
8 trier of fact.

9 (h) If the court makes the finding described by
10 Subsection (g) of this section, the court shall
11 determine reasonable and necessary attorneys' fees to
12 compensate the claimant for attorneys' fees incurred
13 before the date and time of the rejected settlement
14 offer. If the court finds that the amount tendered in
15 the settlement offer to compensate the claimant for
16 attorneys' fees under Subsection (d)(2) of this
17 section is the same as, substantially the same as, or
18 more than the amount of reasonable and necessary
19 attorneys' fees incurred by the claimant as of the date
20 of the offer, the claimant may not recover attorneys'
21 fees greater than the amount of fees tendered in the
22 settlement offer.

23 (i) If the court finds that the offering party
24 could not perform the offer at the time the offer was
25 made or that the offering party substantially
26 misrepresented the cash value of the offer,
27 Subsections (g) and (h) of this section do not apply.

28 (j) If Subsection (g) of this section does not
29 apply, the court shall award damages as required by
30 Section 16(b) of this article. If Subsection (h) of
31 this section does not apply, the court shall award
32 attorneys' fees as required by Section 16(b) of this
33 article.

34 Revised Law

35 Sec. 541.160. EFFECT OF SETTLEMENT OFFER. A settlement
36 offer is not an admission of engaging in an act or practice defined
37 by Subchapter B to be an unfair method of competition or an unfair
38 or deceptive act or practice in the business of insurance.
39 (V.T.I.C. Art. 21.21, Sec. 16A(k).)

40 Source Law

41 (k) An offer of settlement is not an admission
42 of engaging in an act or practice declared in Section 4
43 of this article to be an unfair method of competition
44 or an unfair or deceptive act or practice in the
45 business of insurance.

46 Revised Law

47 Sec. 541.161. MEDIATION. (a) A party may, not later than
48 the 90th day after the date a pleading seeking relief under this
49 subchapter is served, file a motion to compel mediation of the
50 dispute in the manner provided by this section.

51 (b) The court shall, not later than the 30th day after the
52 date a motion under this section is filed, sign an order setting the

1 time and place of the mediation.

2 (c) The court shall appoint a mediator if the parties do not
3 agree on a mediator.

4 (d) The mediation must be held not later than the 30th day
5 after the date the order is signed, unless:

6 (1) the parties agree otherwise; or

7 (2) the court determines that additional time not to
8 exceed 30 days is warranted.

9 (e) Each party who has appeared in the action, except as
10 agreed to by all parties who have appeared, shall:

11 (1) participate in the mediation; and

12 (2) except as provided by Subsection (f), share the
13 mediation fee.

14 (f) A party may not compel mediation under this section if
15 the amount of actual damages claimed is less than \$15,000 unless the
16 party seeking to compel mediation agrees to pay the costs of the
17 mediation.

18 (g) Except as provided by this section, the following apply
19 to the appointment of a mediator and the mediation process provided
20 by this section:

21 (1) Section 154.023, Civil Practice and Remedies Code;
22 and

23 (2) Subchapters C and D, Chapter 154, Civil Practice
24 and Remedies Code. (V.T.I.C. Art. 21.21, Sec. 16B.)

25 Source Law

26 Sec. 16B. (a) A party may, not later than the
27 90th day after the date of service of a pleading in
28 which relief under Section 16 of this article is
29 sought, file a motion to compel mediation of the
30 dispute in the manner provided by this section.

31 (b) The court shall, not later than the 30th day
32 after the date a motion under this section is filed,
33 sign an order setting the time and place of the
34 mediation.

35 (c) If the parties do not agree on a mediator,
36 the court shall appoint the mediator.

37 (d) Mediation shall be held within 30 days after
38 the date the order is signed, unless the parties agree
39 otherwise or the court determines that additional
40 time, not to exceed an additional 30 days, is
41 warranted.

42 (e) Except as agreed to by all parties who have

1 appeared in the action, each party who has appeared
2 shall participate in the mediation and, except as
3 provided by Subsection (f), shall share the mediation
4 fee.

5 (f) A party may not compel mediation under this
6 section if the amount of actual damages claimed is less
7 than \$15,000, unless the party seeking to compel
8 mediation agrees to pay the costs of the mediation.

9 (g) Except as provided in this section, Section
10 154.023, Civil Practice and Remedies Code, and
11 Subchapters C and D, Chapter 154, Civil Practice and
12 Remedies Code, apply to the appointment of a mediator
13 and to the mediation process provided by this section.

14 Revised Law

15 Sec. 541.162. LIMITATIONS PERIOD. (a) A person must
16 bring an action under this chapter before the second anniversary of
17 the following:

18 (1) the date the unfair method of competition or
19 unfair or deceptive act or practice occurred; or

20 (2) the date the person discovered or, by the exercise
21 of reasonable diligence, should have discovered that the unfair
22 method of competition or unfair or deceptive act or practice
23 occurred.

24 (b) The limitations period provided by Subsection (a) may be
25 extended for 180 days if the person bringing the action proves that
26 the person's failure to bring the action within that period was
27 caused by the defendant's engaging in conduct solely calculated to
28 induce the person to refrain from or postpone bringing the action.

29 (V.T.I.C. Art. 21.21, Sec. 16(d).)

30 Source Law

31 (d) All actions under this Article must be
32 commenced within two years after the date on which the
33 unfair method of competition or unfair or deceptive
34 act or practice occurred or within two years after the
35 person bringing the action discovered or, in the
36 exercise of reasonable diligence, should have
37 discovered the occurrence of the unfair method of
38 competition or unfair or deceptive act or practice.
39 The period of limitation provided in this section may
40 be extended for a period of 180 days if the person
41 bringing the action proves that the failure to timely
42 commence the action was caused by the defendant's
43 engaging in conduct solely calculated to induce the
44 plaintiff to refrain from or postpone the commencement
45 of the action.

46 [Sections 541.163-541.200 reserved for expansion]

1 SUBCHAPTER E. ENFORCEMENT BY ATTORNEY GENERAL

2 Revised Law

3 Sec. 541.201. INJUNCTIVE RELIEF. (a) The attorney
4 general may bring an action under this section if the attorney
5 general has reason to believe that:

6 (1) a person engaged in the business of insurance in
7 this state is engaging in, has engaged in, or is about to engage in
8 an act or practice defined as unlawful under:

9 (A) this chapter or a rule adopted under this
10 chapter; or

11 (B) Section 17.46, Business & Commerce Code; and

12 (2) the action is in the public interest.

13 (b) The attorney general may bring the action in the name of
14 the state to restrain by temporary or permanent injunction the
15 person's use of the method, act, or practice. (V.T.I.C.
16 Art. 21.21, Sec. 15(a).)

17 Source Law

18 Sec. 15. (a) If the Attorney General has
19 reason to believe that any person in the insurance
20 business in this state is engaging in, has engaged in,
21 or is about to engage in any act or practice declared
22 to be unlawful by this Article or rules or regulations
23 issued under this Article or by Section 17.46 of the
24 Business & Commerce Code, as amended, and that
25 proceedings would be in the public interest, the
26 Attorney General may bring an action in the name of the
27 state against the person to restrain by temporary or
28 permanent injunction the use of such method, act, or
29 practice.

30 Revised Law

31 Sec. 541.202. VENUE FOR INJUNCTIVE ACTION. An action for
32 an injunction under this subchapter may be commenced in a district
33 court in:

34 (1) the county in which the person against whom the
35 action is brought:

36 (A) resides;

37 (B) has the person's principal place of business;

38 or

39 (C) is engaging in business;

1 (2) the county in which the transaction or a
2 substantial portion of the transaction occurred; or

3 (3) Travis County. (V.T.I.C. Art. 21.21, Sec. 15(b)
4 (part).)

5 Source Law

6 (b) An action brought under Subsection (a) of
7 this section may be commenced in the district court of
8 the county in which the person against whom it is
9 brought resides, has his principal place of business,
10 is doing business, or in the district court of the
11 county where the transaction occurred or any
12 substantial portion of the transaction occurred, or in
13 a district court of Travis County. . . .

14 Revised Law

15 Sec. 541.203. ISSUANCE OF INJUNCTION. (a) The court may
16 issue an appropriate temporary or permanent injunction.

17 (b) The court shall issue the injunction without bond.
18 (V.T.I.C. Art. 21.21, Sec. 15(b) (part).)

19 Source Law

20 (b) . . . The court may issue appropriate
21 temporary or permanent injunctions, and the
22 injunctions shall be issued without bond.

23 Revised Law

24 Sec. 541.204. CIVIL PENALTY. In addition to requesting a
25 temporary or permanent injunction under Section 541.201, the
26 attorney general may request a civil penalty of not more than
27 \$10,000 for each violation on a finding by the court that the
28 defendant has engaged in or is engaging in an act or practice
29 defined as unlawful under:

30 (1) this chapter or a rule adopted under this chapter;
31 or

32 (2) Section 17.46, Business & Commerce Code.
33 (V.T.I.C. Art. 21.21, Sec. 15(c).)

34 Source Law

35 (c) In addition to the request for a temporary
36 or permanent injunction in a proceeding brought under
37 Subsection (a) of this section, the Attorney General,
38 on a finding by the court that the defendant has
39 engaged or is engaging in a practice declared to be
40 unlawful by Article 17.46 of the Business & Commerce
41 Code, as amended, this Article, or rules or
42 regulations issued under this Article, may request a

1 civil penalty of not more than \$10,000 per violation.

2 Revised Law

3 Sec. 541.205. COMPENSATION OR RESTORATION. The court may
4 make an additional order or judgment as necessary to compensate an
5 identifiable person for actual damages or for restoration of money
6 or property that may have been acquired by means of an enjoined act
7 or practice. (V.T.I.C. Art. 21.21, Sec. 15(d).)

8 Source Law

9 (d) The court may make such additional orders or
10 judgments as are necessary to compensate identifiable
11 persons for actual damages or restoration of money or
12 property, real or personal, which may have been
13 acquired by means of any act or practice restrained.

14 Revisor's Note

15 Section 15(d), V.T.I.C. Article 21.21, refers to
16 "real or personal" property. The revised law omits the
17 reference to "real or personal" because under Section
18 311.005(4), Government Code (Code Construction Act),
19 applicable to the revised law, "property" includes
20 both real and personal property.

21 Revised Law

22 Sec. 541.206. CIVIL PENALTY FOR VIOLATION OF INJUNCTION.

23 (a) A person who violates an injunction issued under this
24 subchapter is liable for and shall pay to the state a civil penalty
25 of not more than \$10,000 for each violation.

26 (b) The attorney general may, in the name of the state,
27 petition the court for recovery of the civil penalty against the
28 person who violates the injunction.

29 (c) The court shall consider the maintenance of procedures
30 reasonably adapted to ensure compliance with the injunction in
31 determining whether a person has violated an injunction.

32 (d) The court issuing the injunction retains jurisdiction
33 and the cause is continued for the purpose of assessing a civil
34 penalty under this section. (V.T.I.C. Art. 21.21, Sec. 15(e).)

35 Source Law

36 (e) Any person who violates the terms of an
37 injunction under this section shall forfeit and pay to

1 the state a civil penalty of not more than \$10,000 per
2 violation. In determining whether or not an
3 injunction has been violated the court shall take into
4 consideration the maintenance of procedures
5 reasonably adapted to insure compliance with the
6 injunction. For the purposes of this section, the
7 district court issuing the injunction shall retain
8 jurisdiction, and the cause shall be continued, and in
9 such cases, the Attorney General, acting in the name of
10 the state, may petition for recovery of civil
11 penalties under this section.

12 Revised Law

13 Sec. 541.207. REMEDIES NOT EXCLUSIVE. The remedies
14 provided by this subchapter are:

15 (1) not exclusive; and

16 (2) in addition to any other remedy or procedure
17 provided by another law or at common law. (V.T.I.C. Art. 21.21,
18 Sec. 15(f).)

19 Source Law

20 (f) The remedies in this section are not
21 exclusive and are in addition to any other remedy or
22 procedure provided by any other law or at common law.

23 [Sections 541.208-541.250 reserved for expansion]

24 SUBCHAPTER F. CLASS ACTIONS BY ATTORNEY GENERAL OR PRIVATE

25 INDIVIDUAL

26 Revised Law

27 Sec. 541.251. CLASS ACTION AUTHORIZED. (a) If a member of
28 the insurance buying public has been damaged by an unlawful method,
29 act, or practice defined in Subchapter B as an unlawful deceptive
30 trade practice, the department may request the attorney general to
31 bring a class action or the individual damaged may bring an action
32 on the individual's own behalf and on behalf of others similarly
33 situated to recover damages and obtain relief as provided by this
34 subchapter.

35 (b) A class action may not be maintained under this
36 subchapter if the department and attorney general have initiated an
37 action under Subchapter G or an action under that subchapter has
38 resulted in a final determination regarding the same act or
39 practice and the same defendant in the action under this
40 subchapter. (V.T.I.C. Art. 21.21, Secs. 17(a), (e).)

1 Source Law

2 Sec. 17. (a) If a member of the insurance
3 buying public has been damaged by an unlawful method,
4 act, or practice defined in Section 4 of this Article
5 as an unlawful deceptive trade practice, the Board may
6 request the Attorney General to bring a class action,
7 or the individual damaged may bring an action on behalf
8 of himself and others similarly situated, to recover
9 damages and relief as provided in this section.

10 (e) An action under this section may not be
11 maintained if an administrative class action under
12 Section 14 of this Article has been initiated or has
13 resulted in a final determination regarding the same
14 acts or practices and the same defendant in the action
15 under this section.

16 Revised Law

17 Sec. 541.252. RECOVERY. A plaintiff who prevails in a
18 class action under this subchapter may recover:

19 (1) court costs and attorney's fees reasonable in
20 relation to the amount of work expended in addition to actual
21 damages;

22 (2) an order enjoining the act or failure to act; and

23 (3) any other relief the court determines is proper.

24 (V.T.I.C. Art. 21.21, Sec. 17(b).)

25 Source Law

26 (b) A plaintiff who prevails in a class action
27 under this section may recover:

28 (1) court costs and attorneys' fees
29 reasonable in relation to the amount of work expended
30 in addition to actual damages;

31 (2) an order enjoining the act or failure
32 to act;

33 (3) any other relief which the court deems
34 proper.

35 Revised Law

36 Sec. 541.253. FRIVOLOUS ACTION. The court may award to the
37 defendant court costs and reasonable attorney's fees in relation to
38 the work expended on a finding by the court that a class action
39 under this subchapter was brought by an individual plaintiff in bad
40 faith or for the purpose of harassment. (V.T.I.C. Art. 21.21, Sec.
41 17(c).)

42 Source Law

43 (c) On a finding by the court that an action
44 under this section was brought by an individual
45 plaintiff in bad faith or for the purpose of
46 harassment, the court may award to the defendant

1 reasonable attorneys' fees in relation to the work
2 expended and court costs.

3 Revised Law

4 Sec. 541.254. STATUTE OF LIMITATIONS TOLLED. The filing of
5 a class action under this subchapter tolls the statute of
6 limitations for bringing an action by an individual under Section
7 541.162. (V.T.I.C. Art. 21.21, Sec. 18(k) (part).)

8 Source Law

9 (k) The filing of a suit under this section
10 tolls the statute of limitations for bringing a suit by
11 an individual under Section 16 of this Article. . . .

12 Revised Law

13 Sec. 541.255. PRIOR NOTICE. (a) Not later than the 31st
14 day before the date a class action for damages is commenced under
15 this subchapter, the prospective plaintiff must:

16 (1) notify the intended defendant of the complaint;
17 and

18 (2) demand that the defendant provide relief to the
19 prospective plaintiff and others similarly situated.

20 (b) The notice must be in writing and be sent by certified or
21 registered mail, return receipt requested, to:

22 (1) the place where the transaction occurred;
23 (2) the intended defendant's principal place of
24 business in this state; or

25 (3) if notice to the place described by Subdivision
26 (1) or (2) does not effect notice, the office of the secretary of
27 state.

28 (c) A copy of the notice must also be sent to the
29 commissioner.

30 (d) A class action for injunctive relief may be commenced
31 under this subchapter without complying with Subsection (a).

32 (e) A plaintiff in a class action for injunctive relief
33 under this subchapter may, on or after the 31st day after the date
34 the action is commenced and after complying with Subsection (a),
35 amend the complaint without leave of court to include a request for
36 damages. (V.T.I.C. Art. 21.21, Secs. 19(a), (b), (c).)

1 Source Law

2 Sec. 19. (a) At least 30 days prior to the
3 commencement of a class action suit for damages under
4 Section 17 of this Article, the prospective plaintiff
5 must notify the intended defendant of his complaint
6 and make demand that the defendant provide relief to
7 the prospective plaintiff and others similarly
8 situated. A copy of the notice must also be sent to the
9 commissioner of insurance.

10 (b) The notice must be in writing and sent by
11 certified or registered mail, return receipt
12 requested, to the place where the transaction
13 occurred, the intended defendant's principal place of
14 business in this state, or if neither will effect
15 notice, to the office of the Secretary of State of
16 Texas.

17 (c) An action for injunctive relief under
18 Section 17 of this Article may be commenced without
19 compliance with Subsection (a) of this section. Not
20 less than 30 days after the commencement of an action
21 for injunctive relief, and after compliance with the
22 provisions of Subsection (a) of this section, the
23 plaintiff may amend his complaint without leave of
24 court to include a request for damages.

25 Revised Law

26 Sec. 541.256. PREREQUISITES TO CLASS ACTION. The court
27 shall permit one or more members of a class to sue or be sued as
28 representative parties on behalf of the class only if:

29 (1) the class is so numerous that joinder of all
30 members is impracticable;

31 (2) there are questions of law or fact common to the
32 class;

33 (3) the claims or defenses of the representative
34 parties are typical of the claims or defenses of the class; and

35 (4) the representative parties will fairly and
36 adequately protect the interests of the class. (V.T.I.C.
37 Art. 21.21, Sec. 18(a).)

38 Source Law

39 Sec. 18. (a) The court shall permit one or more
40 members of a class to sue or be sued as representative
41 parties on behalf of the class only if:

42 (1) the class is so numerous that joinder
43 of all members is impracticable;

44 (2) there are questions of law or fact
45 common to the class;

46 (3) the claims or defenses of the
47 representative parties are typical of the claims or
48 defenses of the class; and

49 (4) the representative parties will fairly
50 and adequately protect the interests of the class.

1 Revised Law

2 Sec. 541.257. CLASS ACTIONS MAINTAINABLE. (a) An action
3 may be maintained as a class action under this subchapter if the
4 prerequisites of Section 541.256 are satisfied and, in addition:

5 (1) the prosecution of separate actions by or against
6 individual members of the class would create a risk of:

7 (A) inconsistent or varying adjudications with
8 respect to individual members of the class that would establish
9 incompatible standards of conduct for the party opposing the class;

10 or

11 (B) adjudication with respect to individual
12 members of the class that would as a practical matter be dispositive
13 of the interests of the other members not parties to the
14 adjudications or substantially impair or impede their ability to
15 protect their interests;

16 (2) the party opposing the class has acted or refused
17 to act on grounds generally applicable to the class, making
18 appropriate final injunctive relief or corresponding declaratory
19 relief with respect to the class as a whole; or

20 (3) the court finds that the questions of law or fact
21 common to the members of the class predominate over any questions
22 affecting only individual members and that a class action is
23 superior to other available methods for the fair and efficient
24 adjudication of the controversy.

25 (b) Matters pertinent to a finding under Subsection (a)(3)
26 include:

27 (1) the interest of members of the class in
28 individually controlling the prosecution or defense of separate
29 actions;

30 (2) the extent and nature of any litigation concerning
31 the controversy already commenced by or against members of the
32 class;

33 (3) the desirability or undesirability of
34 concentrating the litigation of the claims in the particular forum;

1 and

2 (4) the difficulties likely to be encountered in the
3 management of a class action.

4 (c) In construing this section, the courts of this state
5 shall be guided by the decisions of the federal courts interpreting
6 Rule 23, Federal Rules of Civil Procedure, as amended. (V.T.I.C.
7 Art. 21.21, Secs. 18(b), (c).)

8 Source Law

9 (b) An action may be maintained as a class
10 action if the prerequisites of Subsection (a) of this
11 section are satisfied and in addition:

12 (1) the prosecution of separate actions by
13 or against individual members of the class would
14 create a risk of:

15 (A) inconsistent or varying
16 adjudications with respect to individual members of
17 the class which would establish incompatible standards
18 of conduct for the party opposing the class; or

19 (B) adjudication with respect to
20 individual members of the class which would as a
21 practical matter be dispositive of the interests of
22 the other members not parties to the adjudications or
23 substantially impair or impede their ability to
24 protect their interests; or

25 (2) the party opposing the class has acted
26 or refused to act on ground generally applicable to the
27 class, thereby making appropriate final injunctive
28 relief or corresponding declaratory relief with
29 respect to the class as a whole; or

30 (3) the court finds that the questions of
31 law or fact common to the members of the class
32 predominate over any questions affecting only
33 individual members, and that a class action is
34 superior to other available methods for the fair and
35 efficient adjudication of the controversy. The
36 matters pertinent to the findings include:

37 (A) the interest of members of the
38 class in individually controlling the prosecution or
39 defense of separate actions;

40 (B) the extent and nature of any
41 litigation concerning the controversy already
42 commenced by or against members of the class;

43 (C) the desirability or
44 undesirability of controversy concentrating the
45 litigation of the claims in the particular forum; and

46 (D) the difficulties likely to be
47 encountered in the management of a class action.

48 (c) In construing this section, the courts of
49 Texas shall be guided by the decisions of the federal
50 courts interpreting Rule 23, Federal Rules of Civil
51 Procedure, as amended.

52 Revisor's Note

53 Section 18(b)(3)(C), V.T.I.C. Article 21.21,
54 provides that a matter pertinent to a court's
55 determination of whether questions of law or fact

1 common to class members predominate over questions
2 affecting only individual members, is "the
3 desirability or undesirability of controversy
4 concentrating the litigation of the claims." Except
5 for the use of the word "controversy," the text of
6 Section 18(b)(3)(C) follows the language of Rule
7 42(b), Texas Rules of Civil Procedure, relating to the
8 maintenance of class actions. The revised law omits
9 "controversy" because the word is nonsensical in
10 context and clearly an error.

11 Revised Law

12 Sec. 541.258. CLASS ACTIONS: ISSUES AND SUBCLASSES
13 AUTHORIZED. When appropriate, an action may be brought or
14 maintained as a class action under this subchapter with respect to
15 particular issues or a class may be divided into subclasses and each
16 subclass treated as a class, and the provisions of this subchapter
17 shall be construed and applied accordingly. (V.T.I.C. Art. 21.21,
18 Sec. 18(h).)

19 Source Law

20 (h) When appropriate, an action may be brought
21 or maintained as a class action with respect to
22 particular issues or a class may be divided into
23 subclasses and each subclass treated as a class, and
24 the provisions of this section shall be construed and
25 applied accordingly.

26 Revised Law

27 Sec. 541.259. DETERMINATION REGARDING WHETHER CLASS ACTION
28 MAY BE MAINTAINED. (a) As soon as practicable after the
29 commencement of an action brought as a class action, the court shall
30 determine by order whether it is to be maintained as a class action
31 under this subchapter.

32 (b) An order under this section may be altered or amended
33 before a decision on the merits.

34 (c) An order determining whether the action may be
35 maintained as a class action under this subchapter is an
36 interlocutory order that is appealable. The procedures applicable

1 to accelerated appeals in the Texas Rules of Appellate Procedure
2 apply to the appeal. (V.T.I.C. Art. 21.21, Sec. 18(d).)

3 Source Law

4 (d) As soon as practicable after the
5 commencement of an action brought as a class action,
6 the court shall determine by order whether it is to be
7 maintained as a class action. An order under this
8 subsection may be altered or amended before a decision
9 on the merits. An order determining that the action
10 may or may not be brought as a class action is an
11 interlocutory order which is appealable and the
12 procedures provided in Rule 385, Texas Rules of Civil
13 Procedure, apply.

14 Revisor's Note

15 Section 18(d), V.T.I.C. Article 21.21, provides
16 that an order determining whether an action may be
17 brought as a class action is an appealable
18 interlocutory order to which "the procedures provided
19 in Rule 385, Texas Rules of Civil Procedure, apply."
20 The revised law substitutes a reference to procedures
21 applicable to accelerated appeals in the Texas Rules
22 of Appellate Procedure for the quoted phrase. The
23 Texas Supreme Court repealed Rule 385 by order of April
24 10, 1986, effective September 1, 1986. The main
25 provision of that rule relating to accelerated appeals
26 in civil cases is now contained in Rule 28, Texas Rules
27 of Appellate Procedure, while provisions relating to
28 deadlines for filing items in an accelerated appeal
29 are contained in Rules 26.1, 35.1, and 38.6, Texas
30 Rules of Appellate Procedure. For this reason, the
31 revised law substitutes the reference to the
32 procedures in the Texas Rules of Appellate Procedure.

33 Revised Law

34 Sec. 541.260. EFFECT OF DENIAL OF CLASS ACTION. A court
35 order denying that an action under this subchapter may be brought as
36 a class action does not affect whether an individual may bring the
37 same or a similar action under Subchapter D. (V.T.I.C. Art. 21.21,
38 Sec. 18(k) (part).)

1 Source Law

2 (k) . . . An order of the court denying the
3 bringing of a suit as a class action does not affect
4 the ability of an individual to bring the same or a
5 similar suit under Section 16 of this Article.

6 Revised Law

7 Sec. 541.261. NOTICE OF CLASS ACTION. (a) If an action is
8 permitted as a class action under this subchapter, the court shall
9 direct to the members of the class the best notice practicable under
10 the circumstances, including individual notice to all members who
11 can be identified through reasonable effort.

12 (b) The notice must contain a statement that:

13 (1) the court will exclude from the class a notified
14 member if the member requests exclusion by a specified date;

15 (2) the judgment, whether favorable or not, includes
16 all members who do not request exclusion; and

17 (3) a member who does not request exclusion may enter
18 an appearance through counsel. (V.T.I.C. Art. 21.21, Secs. 18(e),
19 (f).)

20 Source Law

21 (e) If the action is permitted as a class
22 action, the court shall direct to the members of the
23 class the best notice practicable under the
24 circumstances, including individual notice to all
25 members who can be identified through reasonable
26 effort.

27 (f) The notice shall contain a statement that:

28 (1) the court will exclude the member
29 notified from the class if he so requests by a
30 specified date;

31 (2) the judgment, whether favorable or
32 not, will include all members who do not request
33 exclusion; and

34 (3) any member who does not request
35 exclusion, if he desires, may enter an appearance
36 through counsel.

37 Revised Law

38 Sec. 541.262. PROCEDURES IN CLASS ACTION. In a class
39 action under this subchapter, the court may make appropriate
40 orders:

41 (1) determining the course of proceedings or
42 prescribing measures to prevent undue repetition or complication in
43 the presentation of evidence or argument;

1 (2) requiring, for the protection of the members of
2 the class or otherwise for the fair conduct of the action, that
3 notice be given in a manner the court directs to some or all of the
4 members or the attorney general of:

5 (A) any step in the action;

6 (B) the proposed extent of the judgment; or

7 (C) the opportunity for members to:

8 (i) signify whether the members consider
9 the representation to be fair and adequate;

10 (ii) intervene and present claims or
11 defenses; or

12 (iii) otherwise come into the action;

13 (3) imposing conditions on the representative parties
14 or intervenors;

15 (4) requiring that the pleadings be amended to
16 eliminate allegations relating to representation of absent
17 persons, and that the action proceed accordingly; or

18 (5) dealing with similar procedural matters.
19 (V.T.I.C. Art. 21.21, Sec. 18(j).)

20 Source Law

21 (j) In the conduct of a class action the court
22 may make appropriate orders:

23 (1) determining the course of proceedings
24 or prescribing measures to prevent undue repetition or
25 complication in the presentation of evidence or
26 argument;

27 (2) requiring, for the protection of the
28 members of the class or otherwise for the fair conduct
29 of the action, that notice be given in such manner as
30 the court may direct to some or all of the members or to
31 the Attorney General of any step in the action, or of
32 the proposed extent of the judgment, or of the
33 opportunity of members to signify whether they
34 consider the representation fair and adequate, to
35 intervene and present claims or defenses, or otherwise
36 to come into the action;

37 (3) imposing conditions on the
38 representative parties or on intervenors;

39 (4) requiring that the pleadings be
40 amended to eliminate allegations as to representation
41 of absent persons, and that the action proceed
42 accordingly; or

43 (5) dealing with similar procedural
44 matters.

1 Revised Law

2 Sec. 541.263. EFFECT OF SETTLEMENT OFFER. (a) Damages
3 may not be awarded to a class under this subchapter if, not later
4 than the 30th day after the date the intended defendant receives
5 notice under Section 541.255, the intended defendant provides to
6 the plaintiff by certified or registered mail, return receipt
7 requested, a written settlement offer.

8 (b) The settlement offer must include:

9 (1) a statement that all persons similarly situated
10 have been adequately identified or a reasonable effort to identify
11 those persons has been made;

12 (2) a description of the class identified and the
13 method used to identify that class;

14 (3) a statement that all persons identified have been
15 notified that, on request, the intended defendant will provide
16 relief to those persons and all others similarly situated;

17 (4) a complete explanation of the relief being
18 afforded;

19 (5) a copy of the notice or communication the intended
20 defendant is providing to the members of the class;

21 (6) a statement that the relief being afforded the
22 consumer has been or, if the offer is accepted by the consumer, will
23 be given within a stated reasonable time; and

24 (7) a statement that the practice complained of has
25 ceased.

26 (c) Except as provided by Subsection (d), an attempt to
27 comply with this section by a person receiving a demand is:

28 (1) an offer to compromise;

29 (2) not admissible as evidence; and

30 (3) not an admission of engaging in an unlawful act or
31 practice.

32 (d) A defendant may introduce evidence of compliance or an
33 attempt to comply with this section for the purpose of:

34 (1) establishing good faith; or

1 (2) showing compliance with this section. (V.T.I.C.
2 Art. 21.21, Secs. 19(d), (e).)

3 Source Law

4 (d) No damages may be awarded to a class under
5 Section 17 of this Article if within 30 days of receipt
6 of the notice the intended defendant furnished the
7 plaintiff, by certified or registered mail, return
8 receipt requested, a written offer of settlement. The
9 offer of settlement must include a statement that:

10 (1) all others similarly situated have
11 been adequately identified or a reasonable effort to
12 identify such others has been made, and a description
13 of the class so identified and the method employed to
14 identify them;

15 (2) all persons so identified have been
16 notified that upon request the intended defendant will
17 provide relief to them and all others similarly
18 situated, and a complete explanation of the relief
19 being afforded and a copy of the notice or
20 communication which the intended defendant is
21 providing to the members of the class;

22 (3) the relief being afforded the consumer
23 has been, or if said offer is accepted by the consumer,
24 will be given within a stated reasonable time; and

25 (4) the practice complained of has ceased.

26 (e) Attempts to comply with the provisions of
27 this section by a person receiving a demand shall be an
28 offer to compromise and shall be inadmissible as
29 evidence. Attempts to comply with a demand shall not
30 be considered an admission of engaging in an unlawful
31 act or practice. Evidence of compliance or attempts to
32 comply with the provisions of this section may be
33 introduced by a defendant for the purpose of
34 establishing good faith or to show compliance with the
35 provisions of this section.

36 Revised Law

37 Sec. 541.264. DEFENSES. Damages may not be awarded in a
38 class action under this subchapter if the defendant:

39 (1) proves that the action complained of resulted from
40 a bona fide error, notwithstanding the use of reasonable procedures
41 adopted to avoid an error; and

42 (2) made restitution of any consideration received
43 from any member of the class. (V.T.I.C. Art. 21.21, Sec. 20.)

44 Source Law

45 Sec. 20. No award of damages may be given in any
46 class action filed under Section 17 of this Article if
47 the defendant:

48 (1) proves that the action complained of
49 resulted from a bona fide error notwithstanding the
50 use of reasonable procedures adopted to avoid any
51 error; and

52 (2) made restitution of any consideration
53 received from any member of the class.

1 Revised Law

2 Sec. 541.265. LIMITATIONS PERIOD FOR DAMAGES. In a class
3 action under this subchapter, damages may not include any damages
4 incurred more than two years before the date the action is
5 commenced. (V.T.I.C. Art. 21.21, Sec. 17(d).)

6 Source Law

7 (d) In an action under this section, damages may
8 not include any damages incurred beyond a point two
9 years prior to the institution of the action.

10 Revised Law

11 Sec. 541.266. DISPOSITION. (a) A class action under this
12 subchapter may not be dismissed, settled, or compromised without
13 the approval of the court.

14 (b) Notice of the proposed dismissal, settlement, or
15 compromise shall be given to all members of the class in the manner
16 the court directs. (V.T.I.C. Art. 21.21, Sec. 18(g).)

17 Source Law

18 (g) A class action may not be dismissed,
19 settled, or compromised without the approval of the
20 court, and notice of the proposed dismissal,
21 settlement, or compromise shall be given to all
22 members of the class in such manner as the court
23 directs.

24 Revised Law

25 Sec. 541.267. CONTENTS OF JUDGMENT; NOTICE. (a) The
26 judgment in a class action under this subchapter must describe
27 those to whom the notice under Section 541.261 was directed and who
28 have not requested exclusion and those the court finds to be members
29 of the class.

30 (b) The court shall direct to the members of the class the
31 best notice of the judgment practicable under the circumstances,
32 including individual notice to each member who can be identified
33 through reasonable effort. (V.T.I.C. Art. 21.21, Sec. 18(i).)

34 Source Law

35 (i) The judgment in a class action shall
36 describe those to whom the notice was directed and who
37 have not requested exclusion and those the court finds
38 to be members of the class. The court shall direct to
39 the members of the class the best notice practicable
40 under the circumstances, including individual notice

1 to all members who can be identified through
2 reasonable effort.

3 [Sections 541.268-541.300 reserved for expansion]

4 SUBCHAPTER G. DEPARTMENT ACTION FOR REFUND OF PREMIUMS

5 Revised Law

6 Sec. 541.301. REFUND OF PREMIUMS. (a) After notice and
7 hearing as provided in Subchapter C, the department may require a
8 person to make an accounting under Subsection (b):

9 (1) in connection with a method of competition or act
10 or practice that is the basis of a cease and desist order issued
11 under Section 541.108; or

12 (2) on application of an aggrieved person, in
13 connection with a determination by the department that the
14 aggrieved person and other persons similarly situated were induced
15 to purchase an insurance policy as a result of the person engaging
16 in a method of competition or act or practice in violation of:

17 (A) this chapter or a rule adopted under this
18 chapter; or

19 (B) Section 17.46, Business & Commerce Code.

20 (b) A person required to make an accounting under this
21 section must account for all premiums collected for policies issued
22 by the person during the preceding two years in connection with the
23 acts in violation of this chapter described by Subsection (a)(1) or
24 (2).

25 (c) The department may require the person described by
26 Subsection (a) to:

27 (1) give notice to all persons from whom the premiums
28 were collected; and

29 (2) refund the total of all premiums collected from
30 each person who elects to accept a premium refund in exchange for
31 cancellation of the insurance policy issued.

32 (d) A person who refunds premiums under this section shall
33 deduct from the amount of premiums refunded the amount of benefits
34 actually paid by the person while the insurance policy was in force.
35 (V.T.I.C. Art. 21.21, Sec. 14(a) (part).)

1 Source Law

2 Sec. 14. (a) In connection with the issuance
3 of a cease and desist order as provided in Section 7 of
4 this Article or upon application of any aggrieved
5 person, the Board may, after notice and hearing as
6 provided in Section 6 of this Article, in connection
7 with the issuance of a cease and desist order resulting
8 from a finding that a person has engaged in a method of
9 competition, act or practice in violation of this
10 Article, rules or regulations issued under this
11 Article, or Section 17.46, Business & Commerce Code,
12 as amended, or upon finding by the Board that the
13 aggrieved person and persons similarly situated were
14 induced to purchase a policy of insurance as a result
15 of the person engaging in a method of competition, act
16 or practice in violation of this Article, rules or
17 regulations issued under this Article or Section
18 17.46, Business & Commerce Code, as amended, the Board
19 may require the person to account for all premiums
20 collected for policies issued during the immediately
21 preceding two years in connection with such acts in
22 violation of this Article and require: (i) such person
23 to give notice to all persons from whom such premiums
24 were collected, and (ii) to refund the total of all
25 premiums collected from each such person, electing to
26 accept a premium refund in exchange for cancellation
27 of the policy of insurance issued. Premiums so
28 refunded shall be net of policy benefits actually paid
29 by such person while the policy of insurance was in
30 force. . . .

31 Revisor's Note

32 Section 14(a), V.T.I.C. Article 21.21, refers to
33 premiums collected for policies issued during "the
34 immediately preceding two years." The revised law
35 omits "immediately" as unnecessary and refers to "the
36 preceding two years" because "the preceding two years"
37 means the immediately preceding two years.

38 Revised Law

39 Sec. 541.302. TIME TO MAKE REFUNDS. The department shall
40 specify a reasonable time within which a person required to make
41 premium refunds under Section 541.301 must make the refunds.
42 (V.T.I.C. Art. 21.21, Sec. 14(a) (part).)

43 Source Law

44 (a) . . . The Board shall specify a reasonable
45 time within which the person shall be required to make
46 such premium refunds.

47 Revised Law

48 Sec. 541.303. SANCTION. (a) The department may report to
49 the attorney general a person's failure to comply with the

1 department's requirement to refund premiums within the time
2 specified under Section 541.302. The department may request that
3 the attorney general file an action to enforce the department's
4 requirement to refund premiums.

5 (b) Venue for the action is in a district court in Travis
6 County.

7 (c) The court shall enter an appropriate order to enforce
8 the department's requirement to refund premiums if the court finds
9 that:

10 (1) the requirement was lawfully entered; and

11 (2) the person failed to comply with the requirement.

12 (d) The court may enforce its order through contempt
13 proceedings.

14 (e) The sanction provided by this section is in addition to
15 any other sanctions provided in this code or other applicable laws.
16 (V.T.I.C. Art. 21.21, Sec. 14(b).)

17 Source Law

18 (b) If a person fails to comply with the Board's
19 requirement to refund such premiums within the time
20 specified, the Board may, in addition to any other
21 sanctions provided for in the Insurance Code and other
22 applicable laws, report such failure to the Attorney
23 General and request the Attorney General to file a suit
24 to enforce the Board's requirement for refund of
25 premiums. Venue for such suit shall lie in the
26 District Court of Travis County, Texas, and upon
27 finding by the court that such requirement of the Board
28 was lawfully entered and that the person has failed to
29 comply with such requirement, the Court shall enter an
30 appropriate order to enforce such Board order. The
31 Court may enforce its order through contempt
32 proceedings.

33 Revised Law

34 Sec. 541.304. EVIDENTIARY USE OF COMPLIANCE OR ATTEMPT TO
35 COMPLY. (a) Compliance or an attempt to comply with the
36 department's requirement to refund premiums is:

37 (1) an offer to compromise;

38 (2) not admissible as evidence; and

39 (3) not an admission of engaging in an unlawful act or
40 practice.

41 (b) A defendant may introduce evidence of compliance or an

1 attempt to comply with the department's requirement for the purpose
2 of:

- 3 (1) establishing good faith; or
- 4 (2) showing compliance with the department's
5 requirement. (V.T.I.C. Art. 21.21, Sec. 14(c).)

6 Source Law

7 (c) Compliance or attempts to comply with the
8 Board's requirement to refund premiums shall be an
9 offer to compromise and shall be inadmissible as
10 evidence. Compliance or attempts to comply with the
11 Board's requirement for refund of premium shall not be
12 considered as admission of engaging in an unlawful act
13 or practice. Evidence of compliance or attempts to
14 comply with the Board's requirements of refund or
15 premium may be introduced by the defendant for the
16 purpose of establishing good faith or to show
17 compliance with the Board's requirement.

18 [Sections 541.305-541.350 reserved for expansion]

19 SUBCHAPTER H. ASSURANCE OF VOLUNTARY COMPLIANCE

20 Revised Law

21 Sec. 541.351. ACCEPTANCE OF ASSURANCE. (a) In
22 administering this chapter, the department may accept assurance of
23 voluntary compliance from a person who is engaging in, has engaged
24 in, or is about to engage in an act or practice in violation of:

- 25 (1) this chapter or a rule adopted under this chapter;
- 26 or
- 27 (2) Section 17.46, Business & Commerce Code.

28 (b) The assurance must be in writing and be filed with the
29 department.

30 (c) The department may condition acceptance of an assurance
31 of voluntary compliance on the stipulation that the person offering
32 the assurance restore to a person in interest money that may have
33 been acquired by the act or practice described in Subsection (a).
34 (V.T.I.C. Art. 21.21, Secs. 22(a), (b).)

35 Source Law

36 Sec. 22. (a) In the administration of this
37 Article the Board may accept assurance of voluntary
38 compliance with respect to any act or practice which
39 violates this Article or regulations issued under this
40 Article or any act declared to be unlawful in Section
41 17.46 of the Business & Commerce Code, as amended, from
42 any person who is engaging in, has engaged in, or is

1 about to engage in the act or practice. The assurance
2 shall be in writing and shall be filed with the Board.

3 (b) The acceptance of an assurance of voluntary
4 compliance may be conditioned on the stipulation that
5 the person in violation of this Article or regulations
6 issued under this Article, or Section 17.46, Business
7 & Commerce Code, as amended, restore to any person in
8 interest any money which may have been acquired by
9 means of acts or practices which violate this Article
10 or regulations issued under this Article, or Section
11 17.46, Business & Commerce Code, as amended.

12 Revised Law

13 Sec. 541.352. EFFECT OF ASSURANCE. (a) An assurance of
14 voluntary compliance is not an admission of a prior violation of:

15 (1) this chapter or a rule adopted under this chapter;
16 or

17 (2) Section 17.46, Business & Commerce Code.

18 (b) Unless an assurance of voluntary compliance is
19 rescinded by agreement, a subsequent failure to comply with the
20 assurance is prima facie evidence of a violation of:

21 (1) this chapter or a rule adopted under this chapter;
22 or

23 (2) Section 17.46, Business & Commerce Code.
24 (V.T.I.C. Art. 21.21, Sec. 22(c).)

25 Source Law

26 (c) An assurance of voluntary compliance shall
27 not be considered an admission of prior violation of
28 this Article or regulations issued under this Article
29 or Section 17.46, Business & Commerce Code, as
30 amended. However, unless an assurance has been
31 rescinded by agreement, subsequent failure to comply
32 with the terms of an assurance is prima facie evidence
33 of a violation of this Article or regulations issued
34 under this Article or Section 17.46, Business &
35 Commerce Code, as amended.

36 Revised Law

37 Sec. 541.353. REOPENING. A matter closed by the filing of
38 an assurance of voluntary compliance may be reopened at any time.

39 (V.T.I.C. Art. 21.21, Sec. 22(d) (part).)

40 Source Law

41 (d) Matters closed by the filing of an assurance
42 of voluntary compliance may be reopened at any
43 time. . . .

44 Revised Law

45 Sec. 541.354. RIGHT TO BRING ACTION NOT AFFECTED. An

1 assurance of voluntary compliance does not affect the right of an
2 individual to bring an action under this chapter, except that the
3 right of an individual in relation to money received according to a
4 stipulation under Section 541.351(c) is governed by the terms of
5 the assurance. (V.T.I.C. Art. 21.21, Sec. 22(d) (part).)

6 Source Law

7 (d) . . . Assurance of voluntary compliance
8 shall in no way affect individual rights of action
9 under this Article, except that the right of
10 individuals with regard to money received pursuant to
11 a stipulation in the voluntary compliance under
12 Subsection (b) of this section are governed by the
13 terms of the voluntary compliance.

14 [Sections 541.355-541.400 reserved for expansion]

15 SUBCHAPTER I. RULEMAKING

16 Revised Law

17 Sec. 541.401. RULEMAKING AUTHORITY. (a) The commissioner
18 may adopt and enforce reasonable rules the commissioner determines
19 necessary to accomplish the purposes of this chapter.

20 (b) Notwithstanding a previous definition or interpretation
21 of a term used in this chapter contained in or derived from the
22 common law or other statutory law of this state, the commissioner
23 may adopt an express provision necessary to accomplish the purposes
24 of this chapter, including a provision the commissioner considers
25 necessary to:

26 (1) achieve necessary uniformity with the laws of
27 other states or the United States; or

28 (2) conform to the adopted procedures of the National
29 Association of Insurance Commissioners. (V.T.I.C. Art. 21.21,
30 Sec. 13(a) (part).)

31 Source Law

32 Sec. 13. (a) The State Board of Insurance is
33 authorized to promulgate and may promulgate and
34 enforce reasonable rules and regulations and may order
35 such provision as is necessary in the accomplishment
36 of the purposes of this Article . . . including, but
37 not limited to, such express provision within the
38 purposes of these Articles as it deems necessary or as
39 is required to affect necessary uniformity with the
40 laws of other states or the United States or in
41 conformity with the adopted procedures of the National
42 Association of Insurance Commissioners

1 notwithstanding any previous definition or
2 interpretation of terms used in these Articles had in
3 or derived from the common law or other statutory law
4 of this state.

5 Revisor's Note

6 Section 13(a), V.T.I.C. Article 21.21, refers to
7 "including, but not limited to." The revised law omits
8 "but not limited to" as unnecessary because Section
9 311.005(13), Government Code (Code Construction Act),
10 and Section 312.011(19), Government Code, provide that
11 "includes" and "including" are terms of enlargement
12 and not of limitation and do not create a presumption
13 that components not expressed are excluded.

14 Revised Law

15 Sec. 541.402. PETITION. (a) A petition may be submitted
16 to the commissioner to adopt, amend, or repeal a rule. The petition
17 must be:

18 (1) signed by 100 interested persons; and

19 (2) supported by evidence that:

20 (A) a particular act or practice has been or
21 could be false, misleading, or deceptive to the insurance buying
22 public; or

23 (B) an act or practice defined by department rule
24 to be false, misleading, or deceptive is not false, misleading, or
25 deceptive.

26 (b) Not later than the 30th day after the date the
27 department receives the petition, the department shall:

28 (1) deny the petition as provided by Section 541.403;

29 or

30 (2) initiate hearing proceedings under Section
31 541.404. (V.T.I.C. Art. 21.21, Sec. 13(b).)

32 Source Law

33 (b) A petition may be submitted to the Board to
34 adopt, amend, or repeal a regulation. The petition
35 must be signed by 100 interested persons and supported
36 by evidence that a particular act or practice has been
37 or could be false, misleading or deceptive to the
38 insurance buying public, or that an act or practice
39 declared to be false, misleading, or deceptive by a

1 regulation of the Board is not in fact false,
2 misleading, or deceptive. Within 30 days after
3 receipt of the petition the Board must either deny the
4 petition or initiate hearing proceedings under this
5 section.

6 Revised Law

7 Sec. 541.403. DENIAL OF PETITION. (a) The department
8 must state in writing the reason for denying a petition to adopt,
9 amend, or repeal a rule.

10 (b) The department is expressly authorized to deny the
11 petition if the action sought would:

12 (1) destroy uniformity with the laws of other states
13 or the United States; or

14 (2) not conform to the adopted procedures of the
15 National Association of Insurance Commissioners. (V.T.I.C.
16 Art. 21.21, Sec. 13(c).)

17 Source Law

18 (c) On denial of the petition the Board must
19 state the reason or reasons for denial in writing.
20 Denial is expressly authorized if the action sought by
21 the petition would destroy uniformity with the laws of
22 other states or of the United States or would not be in
23 conformity with the adopted procedures of the National
24 Association of Insurance Commissioners.

25 Revised Law

26 Sec. 541.404. HEARING ON PETITION. (a) A hearing held by
27 the department in response to a petition to adopt, amend, or repeal
28 a rule must be open to the public.

29 (b) At the hearing, any person may present to the department
30 in writing or orally testimony, data, or other information
31 regarding the act or practice under consideration. (V.T.I.C.
32 Art. 21.21, Sec. 13(d).)

33 Source Law

34 (d) If in response to the petition the Board
35 determines to hold a hearing, such hearing shall be
36 open to the public and any person may present
37 testimony, data, or other information in writing or
38 orally to the Board regarding the acts or practices
39 under consideration.

40 Revised Law

41 Sec. 541.405. JUDICIAL REVIEW OF DEPARTMENT ACTION. (a) A
42 person aggrieved by the denial of a petition under Section 541.402

1 or the adoption, amendment, or repeal of or failure to adopt a rule
2 under this subchapter may file a petition in a district court in
3 Travis County for:

4 (1) a declaratory judgment on the validity or
5 applicability of an adopted, amended, or repealed rule; or

6 (2) review of the denial of a petition under Section
7 541.402.

8 (b) The commissioner must be made a party to the action.

9 (c) An action of the commissioner under this subchapter in
10 adopting, amending, repealing, or failing to adopt a rule or
11 denying a petition may be invalidated only if the court finds that
12 the action:

13 (1) violates a constitutional or state statutory
14 provision;

15 (2) exceeds the commissioner's statutory authority;

16 (3) is arbitrary or capricious or characterized by
17 abuse of discretion or unwarranted exercise of discretion;

18 (4) is so vague that it does not establish
19 sufficiently definite standards to which conduct can be conformed;

20 (5) is made following unlawful procedure; or

21 (6) is clearly erroneous in view of the reliable,
22 probative, and substantial evidence in the whole record as
23 submitted.

24 (d) The court may issue an injunction in an action under
25 this section. (V.T.I.C. Art. 21.21, Secs. 13(e), (f).)

26 Source Law

27 (e) A person aggrieved by the denial of the
28 hearing under Subsection (b) of this section or by the
29 adoption, amendment, or repeal of a regulation or
30 failure to issue a regulation under this section, may
31 file a petition in a district court of Travis County
32 for a declaratory judgment on the validity or
33 applicability of a regulation adopted, amended, or
34 repealed under this section or on the denial of a
35 hearing under Subsection (b) of this section. The
36 Board shall be made a party to the action. In a suit
37 under this subsection the district court may issue
38 injunctions.

39 (f) The action of the Board in adopting,
40 amending, repealing, or failing to adopt a regulation
41 or denying a hearing may be invalidated only if it is

1 found that it:

2 (1) violates a constitutional or state
3 statutory provision;

4 (2) exceeds the statutory authority of the
5 Board;

6 (3) is arbitrary or capricious or
7 characterized by abuse of discretion or unwarranted
8 exercise of discretion;

9 (4) is so vague that it does not establish
10 sufficiently definite standards with which conduct can
11 be conformed;

12 (5) is made on unlawful procedure; or

13 (6) is clearly erroneous in view of the
14 reliable, probative, and substantial evidence in the
15 whole record as submitted.

16 [Sections 541.406-541.450 reserved for expansion]

17 SUBCHAPTER J. CONSTRUCTION OF CHAPTER WITH OTHER LAWS

18 Revised Law

19 Sec. 541.451. LIABILITY UNDER OTHER LAW. An order of the
20 department under this chapter or an order by a court to enforce that
21 order does not relieve or absolve a person affected by either order
22 from liability under another law of this state. (V.T.I.C.
23 Art. 21.21, Sec. 8.)

24 Source Law

25 Sec. 8. No order of the Board under this Act or
26 order of a court to enforce the same shall in any way
27 relieve or absolve any person affected by such order
28 from any liability under any other laws of this state.

29 Revised Law

30 Sec. 541.452. POWERS IN ADDITION TO OTHER POWERS AUTHORIZED
31 BY LAW. The powers vested in the department and the commissioner
32 by this chapter are in addition to any other powers to enforce a
33 penalty, fine, or forfeiture authorized by law with respect to a
34 method of competition or act or practice defined as unfair or
35 deceptive. (V.T.I.C. Art. 21.21, Sec. 11.)

36 Source Law

37 Sec. 11. The powers vested in the Board by this
38 Act shall be additional to any other powers to enforce
39 any penalties, fines or forfeitures authorized by law
40 with respect to the methods, acts and practices hereby
41 declared to be unfair or deceptive.

42 Revised Law

43 Sec. 541.453. DOUBLE RECOVERY PROHIBITED. A person may not
44 recover damages and penalties for the same act or practice under
45 both this chapter and another law. (V.T.I.C. Art. 21.21, Sec.

1 11A.)

2 Source Law

3 Sec. 11A. A person may not recover damages and
4 penalties for the same act or practice under both this
5 Article and under another law.

6 Revised Law

7 Sec. 541.454. PENALTIES AND RELATED PAYMENTS BY INSURER.

8 (a) Civil penalties, premium refunds, judgments, compensatory
9 judgments, individual recoveries, orders, class action awards,
10 costs, damages, or attorney's fees assessed or awarded under this
11 chapter:

12 (1) may be paid only from the capital or surplus funds
13 of the offending insurer; and

14 (2) may not take precedence over, be in priority to, or
15 in any other manner apply to:

16 (A) Article 21.28-C or 21.28-D or any other
17 insurance guaranty act; or

18 (B) Article 21.39-A.

19 (b) The statutes described by Subsection (a)(2) and the
20 priorities of funds created by those statutes are exempt from the
21 provisions of this chapter. (V.T.I.C. Art. 21.21, Sec. 23.)

22 Source Law

23 Sec. 23. Those civil penalties, premium
24 refunds, judgments, compensatory judgments,
25 individual recoveries, orders, class action awards,
26 costs, damages, or attorneys' fees which are assessed
27 or awarded as provided in this Article shall be paid
28 only from the capital or surplus funds of the offending
29 insurance company, and no such payments shall take
30 precedence over, be in priority to, or in any manner be
31 applicable to the provisions of Article 21.28-B, Texas
32 Insurance Code, known as the Loss Claimant's
33 Priorities Act, Article 21.28-C, Texas Insurance
34 Code, known as the Property and Casualty Insurance
35 Guaranty Act, Article 21.28-D, Texas Insurance Code,
36 known as the Life, Accident, Health, and Hospital
37 Service Insurance Guaranty Association Act, Article
38 21.28-E, Texas Insurance Code, known as the Texas
39 Life, Health and Accident Guaranty Act, any other
40 similar insurance guaranty act hereafter enacted by
41 the Texas Legislature, or Article 21.39-A, Texas
42 Insurance Code, known as the Asset Protection Act, and
43 such special statutes and the priorities of funds
44 created thereby shall be exempt from the provisions of
45 this Article.

1 Revisor's Note

2 (1) Section 23, V.T.I.C. Article 21.21, refers
3 to "Article 21.28-B, Texas Insurance Code, known as
4 the Loss Claimant's Priorities Act." That article was
5 repealed by Section 6.21, Chapter 1082, Acts of the
6 71st Legislature, Regular Session, 1989, and the
7 revised law omits the reference accordingly.

8 (2) Section 23, V.T.I.C. Article 21.21, refers
9 to "Article 21.28-E, Texas Insurance Code, known as
10 the Texas Life, Health and Accident Guaranty Act."
11 That article was repealed by Section 48, Chapter 1073,
12 Acts of the 70th Legislature, Regular Session, 1987,
13 and the revised law omits the reference accordingly.

14 Revisor's Note
15 (End of Chapter)

16 Section 24, V.T.I.C. Article 21.21, contains a
17 transitional provision relating to acts or omissions
18 before the effective date of the statute. The revised
19 law omits the transitional provision as executed. The
20 omitted law reads:

21 Sec. 24. No remedy or civil penalty
22 shall lie or exist by reason of any act or
23 omission occurring prior to the effective
24 date of this Act.

25 CHAPTER 542. PROCESSING AND SETTLEMENT OF CLAIMS

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9 Sec. 542.205. ENFORCEMENT; RULES 299

10 CHAPTER 542. PROCESSING AND SETTLEMENT OF CLAIMS

11 SUBCHAPTER A. UNFAIR CLAIM SETTLEMENT PRACTICES

12 Revised Law

13 Sec. 542.001. SHORT TITLE. This subchapter may be cited as
14 the Unfair Claim Settlement Practices Act. (V.T.I.C. Art. 21.21-2,
15 Sec. 1.)

16 Source Law

17 Art. 21.21-2
18 Sec. 1. This Act shall be known as the Unfair
19 Claim Settlement Practices Act.

20 Revised Law

21 Sec. 542.002. APPLICABILITY OF SUBCHAPTER. This subchapter
22 applies to the following insurers whether organized as a
23 proprietorship, partnership, stock or mutual corporation, or
24 unincorporated association:

- 25 (1) a life, health, or accident insurance company;
- 26 (2) a fire or casualty insurance company;
- 27 (3) a hail or storm insurance company;
- 28 (4) a title insurance company;
- 29 (5) a mortgage guarantee company;
- 30 (6) a mutual assessment company;
- 31 (7) a local mutual aid association;
- 32 (8) a local mutual burial association;
- 33 (9) a statewide mutual assessment company;
- 34 (10) a stipulated premium company;
- 35 (11) a fraternal benefit society;

- 1 (12) a group hospital service corporation;
2 (13) a county mutual insurance company;
3 (14) a Lloyd's plan;
4 (15) a reciprocal or interinsurance exchange; and
5 (16) a farm mutual insurance company. (V.T.I.C.
6 Art. 21.21-2, Sec. 7.)

7 Source Law

8 Sec. 7. The provisions of this Act are to
9 specifically apply to the following insuring
10 organizations: proprietorships, partnerships,
11 corporations and unincorporated associations, stock
12 and mutual life, health, accident, fire, casualty,
13 fire and casualty, hail, storm, title, and mortgage
14 guarantee companies; mutual assessment companies;
15 local mutual aid associations; local mutual burial
16 associations; statewide mutual assessment companies;
17 stipulated premium companies; fraternal benefit
18 societies; group hospital service organizations;
19 county mutual insurance companies; Lloyds; reciprocal
20 or inter-insurance exchanges and farm mutual insurance
21 companies.

22 Revisor's Note

23 Section 7, V.T.I.C. Article 21.21-2, refers to
24 "group hospital service organizations," meaning
25 corporations operating under Chapter 842 of this code.
26 The term most frequently used to refer to such a
27 corporation is "group hospital service corporation."
28 Consequently, the revised law substitutes "group
29 hospital service corporation" for "group hospital
30 service organizations" to provide for consistent use
31 of terminology in this code.

32 Revised Law

33 Sec. 542.003. UNFAIR CLAIM SETTLEMENT PRACTICES
34 PROHIBITED. (a) An insurer engaging in business in this state may
35 not engage in an unfair claim settlement practice.

36 (b) Any of the following acts by an insurer constitutes
37 unfair claim settlement practices:

- 38 (1) knowingly misrepresenting to a claimant pertinent
39 facts or policy provisions relating to coverage at issue;
40 (2) failing to acknowledge with reasonable promptness

1 pertinent communications relating to a claim arising under the
2 insurer's policy;

3 (3) failing to adopt and implement reasonable
4 standards for the prompt investigation of claims arising under the
5 insurer's policies;

6 (4) not attempting in good faith to effect a prompt,
7 fair, and equitable settlement of a claim submitted in which
8 liability has become reasonably clear;

9 (5) compelling a policyholder to institute a suit to
10 recover an amount due under a policy by offering substantially less
11 than the amount ultimately recovered in a suit brought by the
12 policyholder;

13 (6) failing to maintain the information required by
14 Section 542.005; or

15 (7) committing another act the commissioner
16 determines by rule constitutes an unfair claim settlement practice.
17 (V.T.I.C. Art. 21.21-2, Secs. 2(a), (b) (part).)

18 Source Law

19 Sec. 2. (a) No insurer doing business in this
20 state under the authority, rules and regulations of
21 this code shall engage in unfair claim settlement
22 practices.

23 (b) Any of the following acts by an insurer
24 shall constitute unfair claim settlement practices:

25 (1) Knowingly misrepresenting to
26 claimants pertinent facts or policy provisions
27 relating to coverages at issue;

28 (2) Failing to acknowledge with reasonable
29 promptness pertinent communications with respect to
30 claims arising under its policies;

31 (3) Failing to adopt and implement
32 reasonable standards for prompt investigation of
33 claims arising under its policies;

34 (4) Not attempting in good faith to
35 effectuate prompt, fair, and equitable settlements of
36 claims submitted in which liability has become
37 reasonably clear;

38 (5) Compelling policyholders to institute
39 suits to recover amounts due under its policies by
40 offering substantially less than the amounts
41 ultimately recovered in suits brought by them;

42 (6) Failure of any insurer [to maintain a
43 complete record of all the complaints which it has
44 received during the preceding three years or since the
45 date of its last examination by the commissioner,
46 whichever time is shorter. . . .]; or

47 (7) Committing other actions which the
48 State Board of Insurance has defined, by regulations
49 adopted pursuant to the rule-making authority granted

1 it by this Act, as unfair claim settlement practices.

2 Revisor's Note

3 (1) Section 2(a), V.T.I.C. Article 21.21-2,
4 prohibits an "insurer doing business in this state
5 under the authority, rules and regulations of this
6 code" from engaging in unfair claim settlement
7 practices. The revised law omits the reference to
8 "under the authority, rules and regulations of this
9 code" as unnecessary because an insurer may only
10 engage in business in this state in accordance with the
11 provisions of this code.

12 (2) Section 2(b)(7), V.T.I.C. Article 21.21-2,
13 refers to the State Board of Insurance. Chapter 685,
14 Acts of the 73rd Legislature, Regular Session, 1993,
15 abolished the board and transferred its functions to
16 the commissioner of insurance and the Texas Department
17 of Insurance. Throughout this chapter, references to
18 the board have been changed appropriately.

19 Revised Law

20 Sec. 542.004. EXAMINATION OF TAX RETURNS PROHIBITED. (a)
21 An insurer regulated under this code may not require a claimant, as
22 a condition of settling a claim, to produce the claimant's federal
23 income tax returns for examination or investigation by the insurer
24 unless:

25 (1) the claimant is ordered to produce the tax returns
26 by a court; or

27 (2) the claim involves:

28 (A) a fire loss; or

29 (B) a loss of profits or income.

30 (b) An insurer that violates this section commits:

31 (1) a prohibited practice under this subchapter; and

32 (2) a deceptive trade practice under Subchapter E,
33 Chapter 17, Business & Commerce Code.

34 (c) A claimant affected by a violation of this section is

1 entitled to remedies under Subchapter E, Chapter 17, Business &
2 Commerce Code. (V.T.I.C. Art. 21.21-2, Sec. 2(c).)

3 Source Law

4 (c) An insurer regulated under this code may not
5 require a claimant, as a condition of settling a claim,
6 to produce the claimant's federal income tax returns
7 for examination or investigation by the insurer unless
8 the claimant is ordered to produce those tax returns by
9 a court of competent jurisdiction, the claim involves
10 a fire loss, or the claim involves a loss of profits or
11 income. In addition to committing a prohibited
12 practice under this article, an insurer who violates
13 this subsection commits a deceptive trade practice
14 under Subchapter E, Chapter 17, Business & Commerce
15 Code, and an affected claimant is entitled to remedies
16 under that subchapter.

17 Revisor's Note

18 Section 2(c), V.T.I.C. Article 21.21-2, refers to
19 a court "of competent jurisdiction." Throughout this
20 chapter, the revised law omits the quoted language as
21 unnecessary because the general laws of civil
22 jurisdiction determine which courts have jurisdiction
23 over a matter. For example, see Sections
24 24.007-24.011, Government Code, for the general
25 jurisdiction of district courts.

26 Revised Law

27 Sec. 542.005. RECORD OF COMPLAINTS. (a) In this section,
28 "complaint" means any written communication primarily expressing a
29 grievance.

30 (b) An insurer shall maintain a complete record of all
31 complaints received by the insurer during the preceding three years
32 or since the date of the insurer's last examination by the
33 department, whichever period is shorter. The record must indicate:

34 (1) the total number of complaints;

35 (2) the classification of complaints by line of
36 insurance;

37 (3) the nature of each complaint;

38 (4) the disposition of the complaints; and

39 (5) the time spent processing each complaint.

40 (V.T.I.C. Art. 21.21-2, Sec. 2(b) (part).)

1 Source Law

2 [(b) Any of the following acts by an insurer
3 shall constitute unfair claim settlement practices:

4 (6) Failure of any insurer] to maintain a
5 complete record of all the complaints which it has
6 received during the preceding three years or since the
7 date of its last examination by the commissioner,
8 whichever time is shorter. This record shall indicate
9 the total number of complaints, their classification
10 by line of insurance, the nature of each complaint, the
11 disposition of these complaints and the time it took to
12 process each complaint. For the purposes of this
13 subsection, "complaint" means any written
14 communication primarily expressing a
15 grievance

16 Revised Law

17 Sec. 542.006. PERIODIC REPORTING REQUIREMENT. (a) In
18 this section, "claim" means a written claim filed by a resident of
19 this state with an insurer engaging in business in this state.

20 (b) If, based on complaints of unfair claim settlement
21 practices under this subchapter, the department finds that an
22 insurer should be subjected to closer supervision with respect to
23 the insurer's claim settlement practices, the department may
24 require the insurer to file periodic reports at intervals the
25 department determines necessary.

26 (c) The department shall devise a statistical plan for the
27 periodic reports required under Subsection (b). The plan must
28 contain at a minimum:

29 (1) the following claims information for the preceding
30 12 months or from the date of the insurer's last periodic report,
31 whichever period is shorter:

32 (A) the total number of claims filed, including
33 for each individual claim:

34 (i) the original amount filed for by the
35 insured; and

36 (ii) the classification by line of
37 insurance;

38 (B) the total number of claims denied;

39 (C) the total number of claims settled, including
40 for each individual claim:

1 (i) the original amount filed for by the
2 insured;

3 (ii) the amount settled; and

4 (iii) the classification by line of
5 insurance; and

6 (D) the total number of claims for which suits
7 have been instituted against the insurer, including for each
8 individual claim:

9 (i) the original amount filed for by the
10 insured;

11 (ii) the amount of final adjudication;

12 (iii) the reason for the suit; and

13 (iv) the classification by line of
14 insurance; and

15 (2) the information required to be maintained by the
16 insurer under Section 542.005.

17 (d) If at any time the department determines that the
18 requirement to file a periodic report is no longer necessary to
19 accomplish the objectives of this subchapter, the department may
20 rescind the reporting requirement. (V.T.I.C. Art. 21.21-2, Sec.
21 3.)

22 Source Law

23 Sec. 3. If it shall be found by the State Board
24 of Insurance, based on complaints of unfair claims
25 settlement practices as defined in Section 2 of this
26 Act, that an insurer should be subjected to closer
27 supervision with respect to such practices, it may
28 require such insurer to file a report at such periodic
29 intervals as the board deems necessary. The board
30 shall also devise a statistical plan for such periodic
31 reports, which is to contain a minimum of the following
32 information:

33 (a) The total number of written claims
34 filed, including the original amount filed for by the
35 insured and the classification by line of insurance of
36 each individual written claim, for the past 12 month
37 period or from the date of the insurer's last periodic
38 report, whichever time is shorter;

39 (b) The total number of written claims
40 denied, for the past 12 month period or from the date
41 of the insurer's last periodic report, whichever time
42 is shorter;

43 (c) The total number of written claims
44 settled, including the original amount filed for by
45 the insured, the settled amount, and the

1 classification of line of insurance of each individual
2 settled claim, for the past 12 month period or from the
3 date of the insurer's last periodic report, whichever
4 time is shorter;

5 (d) The total number of written claims for
6 which lawsuits were instituted against the insurer,
7 including the original amount filed for by the
8 insured, the amount of final adjudication, the reason
9 for the lawsuit and the classification by line of
10 insurance of each individual written claim, for the
11 past 12 month period or from the date of the insurer's
12 last periodic report, whichever time is shorter; and

13 (e) All information required by Subsection
14 (f) of Section 2 of this Act.

15 For the purposes of this section, "written claim"
16 shall include only those claims reduced to writing and
17 filed by a Texas resident with an insurer as defined in
18 Section 2 of this Act. The board may, at any time,
19 rescind the requirement to file periodic reports if it
20 finds that such requirement is no longer necessary to
21 accomplish the objectives set out in this Act.

22 Revisor's Note

23 Section 3(e), V.T.I.C. Article 21.21-2, states
24 that the statistical plan required by that section
25 must contain "[a]ll information required by Subsection
26 (f) of Section 2 of this Act." Section 2(f), V.T.I.C.
27 Article 21.21-2, was redesignated as Section 2(b)(6)
28 by Section 21.01, Chapter 12, Acts of the 72nd
29 Legislature, 2nd Called Session, 1991. The revised
30 law is drafted to reflect that redesignation.

31 Revised Law

32 Sec. 542.007. COMPARISON OF CERTAIN INSURERS TO MINIMUM
33 STANDARD OF PERFORMANCE; INVESTIGATION. (a) The department shall
34 compile the information received from an insurer under Section
35 542.006 in a manner that enables the department to compare the
36 insurer's performance to a minimum standard of performance adopted
37 by the commissioner.

38 (b) If the department determines that the insurer does not
39 meet the minimum standard of performance, the department shall
40 investigate the insurer to determine the reason, if any, that the
41 insurer does not meet the minimum standard. (V.T.I.C.
42 Art. 21.21-2, Sec. 4(b).)

43 Source Law

44 (b) The commissioner shall compile the
45 information received from an insurer pursuant to

1 Section 3 of this Act in such a manner as to enable him
2 to compare it to a minimum standard of performance
3 which shall be promulgated by the State Board of
4 Insurance. If the commissioner, after such comparison
5 is made, finds that the insurer falls below the minimum
6 standard of performance, he shall cause an
7 investigation to be made of said insurer as to the
8 reason, if any, for said substandard performance.

9 Revised Law

10 Sec. 542.008. COMPLAINTS AGAINST INSURERS; INVESTIGATION.

11 (a) The department shall establish a system for receiving and
12 processing individual complaints alleging a violation of this
13 subchapter by an insurer regardless of whether the insurer is
14 required to file a periodic report under Section 542.006.

15 (b) The department shall investigate an insurer if the
16 department determines that:

17 (1) based on the number and type of complaints against
18 an insurer, the insurer does not meet the minimum standard of
19 performance adopted under Section 542.007; or

20 (2) the number and type of complaints against the
21 insurer are not proportionate to the number and type of complaints
22 against other insurers writing similar lines of insurance.

23 (V.T.I.C. Art. 21.21-2, Sec. 4(c).)

24 Source Law

25 (c) The commissioner shall also provide for the
26 receiving and processing of individual complaints
27 alleging violations of this Act by both insurers who
28 are required to make periodic reports and those who are
29 not required to make such reports. If the commissioner
30 in his complaint experience determines that the number
31 and type of complaints against an insurer do not meet
32 the board's minimum standard of performance and/or are
33 out of proportion to those against other insurers
34 writing similar lines of insurance, he shall cause an
35 investigation to be made of the respective insurer.

36 Revised Law

37 Sec. 542.009. REVIEW OF INVESTIGATION RESULTS; HEARING.

38 (a) On receiving the results of an investigation instituted under
39 Section 542.007 or 542.008, the department shall review those
40 results considering the standards of this subchapter to determine
41 whether further action is necessary.

42 (b) If the department determines that further action is
43 necessary, the department shall:

1 (1) set a date for a hearing to review the alleged
2 violations of this subchapter; and

3 (2) notify the insurer of:

4 (A) the date of the hearing; and

5 (B) the nature of the charges.

6 (c) The department shall provide the notice required by
7 Subsection (b)(2) not later than the 30th day before the date of the
8 hearing.

9 (d) At a hearing under this section, the insurer may present
10 the insurer's case with the assistance of counsel.

11 (e) Evidence relating to the number and type of complaints
12 or claims prepared by the department from information received or
13 compiled under Section 542.006, 542.007, or 542.008 is admissible
14 in evidence at:

15 (1) the hearing; and

16 (2) any related judicial proceeding.

17 (f) The hearing shall be conducted in accordance with this
18 code and rules adopted by the commissioner.

19 (g) An insurer may not be found to be in violation of this
20 subchapter solely because of the number and type of complaints or
21 claims against the insurer. (V.T.I.C. Art. 21.21-2, Sec. 5(a).)

22 Source Law

23 Sec. 5. (a) Upon the receipt of the results of
24 an investigation instituted pursuant to Section 4 of
25 this Act, the commissioner shall review the results
26 and shall determine whether, in the light of the
27 standards set out in Section 2 of this Act, further
28 action is required. If the commissioner deems further
29 action necessary, he shall set a date for a public
30 hearing to review the alleged violations of this Act.
31 At such public hearings, the accused insurer shall be
32 permitted to present his case with the assistance of
33 counsel. Any evidence as to numbers and types of
34 complaints or claims prepared by the commissioner,
35 pursuant to Sections 3 and 4 of this Act, shall be
36 admissible in evidence in such hearings or any
37 judicial proceeding pursuant thereof. Notice as to
38 the date of such hearing and the nature of the charges
39 is to be given the insurer not later than 30 days prior
40 to the date set for the hearing. Such hearings are to
41 be conducted pursuant to the rules and regulations
42 promulgated by the State Board of Insurance and the
43 provisions of the Insurance Code, as amended.
44 Provided, that no insurer shall be deemed in violation
45 of this Act solely by reason of the numbers and types

1 of such complaints or claims.

2 Revisor's Note

3 (1) Section 5(a), V.T.I.C. Article 21.21-2,
4 refers to a "public hearing." The revised law omits
5 "public" as unnecessary. The specific procedures for
6 conducting hearings in this context are established by
7 the law applicable to proceedings before state
8 agencies generally, including Chapter 2001,
9 Government Code.

10 (2) Section 5(a), V.T.I.C. Article 21.21-2,
11 refers to "rules and regulations." Throughout this
12 chapter, the revised law omits references to
13 "regulations" in this context because under Section
14 311.005(5), Government Code (Code Construction Act),
15 applicable to the revised law, a rule is defined to
16 include a regulation.

17 (3) Section 5(a), V.T.I.C. Article 21.21-2,
18 refers to "the provisions of the Insurance Code, as
19 amended." The revised law omits the reference to "as
20 amended" because under Section 311.027, Government
21 Code (Code Construction Act), applicable to the
22 revised law, unless expressly provided otherwise, a
23 reference to a statute applies to all reenactments,
24 revisions, or amendments of the statute.

25 (4) Section 5(b), V.T.I.C. Article 21.21-2,
26 permits review by the State Board of Insurance of any
27 ruling or action of the commissioner of insurance "by
28 making an application to the board as provided for in
29 Article 1.04 of the Insurance Code, as amended." The
30 revised law omits this provision as obsolete and
31 unnecessary. Chapter 685, Acts of the 73rd
32 Legislature, Regular Session, 1993, abolished the
33 State Board of Insurance and transferred its functions
34 to the commissioner of insurance and the Texas

1 Department of Insurance. In that same act, V.T.I.C.
2 Article 1.04 was amended to provide for judicial
3 review of an order of the commissioner. Article 1.04
4 was revised in 1999 as Subchapter D, Chapter 36, of
5 this code, and provides sufficient authority for
6 judicial review of a ruling or order of the
7 commissioner under this subchapter. Furthermore,
8 Section 6(b), V.T.I.C. Article 21.21-2, revised in
9 Section 542.011, explicitly refers to the application
10 of Article 1.04. The omitted law reads:

11 (b) Any insurer which is affected by
12 any ruling or action of the commissioner
13 shall have the right to have such ruling or
14 action reviewed by the State Board of
15 Insurance by making an application to the
16 board as provided for in Article 1.04 of the
17 Insurance Code, as amended.

18 Revised Law

19 Sec. 542.010. CEASE AND DESIST ORDER; ENFORCEMENT. (a) If
20 the department determines that an insurer has violated this
21 subchapter, the department shall issue a cease and desist order to
22 the insurer directing the insurer to stop the unlawful practice.

23 (b) If the insurer fails to comply with the cease and desist
24 order, the department may:

25 (1) revoke or suspend the insurer's certificate of
26 authority; or

27 (2) limit, regulate, and control:

28 (A) the insurer's line of business;

29 (B) the insurer's writing of policy forms or
30 other particular forms; and

31 (C) the volume of the insurer's:

32 (i) line of business; or

33 (ii) writing of policy forms or other
34 particular forms.

35 (c) The department shall exercise authority under this
36 section to the extent that the department determines is necessary
37 to obtain the insurer's compliance with the cease and desist order.

1 (d) At the request of the department, the attorney general
2 shall assist the department in enforcing the cease and desist
3 order. (V.T.I.C. Art. 21.21-2, Sec. 6(a).)

4 Source Law

5 Sec. 6. (a) The State Board of Insurance, upon
6 finding an insurer in violation of the provisions of
7 this Act, shall issue a cease and desist order to said
8 insurer directing it to stop such unlawful practices.
9 If the insurer refuses or fails to comply with said
10 order, the board shall have the authority to revoke or
11 suspend the insurer's certificate of authority as
12 provided for in the Insurance Code, as amended. The
13 board shall also have the authority to limit,
14 regulate, and control the insurer's line of business,
15 the insurer's writing of policy forms or other
16 particular forms, and the insurer's volume of its line
17 of business or its writing of policy forms or other
18 particular forms. The board shall use the above
19 authority to the extent it deems necessary to obtain
20 the insurer's compliance to its order. The attorney
21 general shall offer his assistance if requested by the
22 board to enforce the board's orders.

23 Revisor's Note

24 Section 6(a), V.T.I.C. Article 21.21-2, refers to
25 an insurer that "refuses or fails" to comply with an
26 order of the State Board of Insurance. The revised law
27 omits the reference to "refuses" because in context
28 "refuses" is included within the meaning of "fails."

29 Revised Law

30 Sec. 542.011. TIME LIMIT TO APPEAL. An insurer affected by
31 a ruling or order of the department under this subchapter may appeal
32 the ruling or order, in accordance with Subchapter D, Chapter 36, by
33 filing a petition for judicial review not later than the 20th day
34 after the date of the ruling or order. (V.T.I.C. Art. 21.21-2, Sec.
35 6(b) (part).)

36 Source Law

37 (b) Any insurer affected by a ruling or order of
38 the board pursuant to the provisions of this Act may
39 appeal same by filing suit within 20 days from the date
40 of the order of said board. Such appeal shall be
41 governed by Article 1.04 of this code. . . .

42 Revisor's Note

43 Section 6(b), V.T.I.C. Article 21.21-2, permits
44 appeal of any ruling or order of the State Board of

1 Insurance "by filing suit" not later than a certain
2 date and requires that the appeal be governed by
3 V.T.I.C. Article 1.04, revised in 1999 as Subchapter
4 D, Chapter 36, of this code. The revised law refers
5 instead to "filing a petition for judicial review"
6 because that is the procedure provided by Subchapter
7 D, Chapter 36.

8 Revised Law

9 Sec. 542.012. ATTORNEY'S FEES. The department is entitled
10 to reasonable attorney's fees if judicial action is necessary to
11 enforce an order of the department under this subchapter.
12 (V.T.I.C. Art. 21.21-2, Sec. 6(b) (part).)

13 Source Law

14 (b) . . . Reasonable attorneys' fees shall be
15 awarded the board if judicial action is necessary for
16 the enforcement of its orders.

17 Revised Law

18 Sec. 542.013. PERSONNEL. The department may hire
19 employees and examiners as needed to enforce this subchapter.
20 (V.T.I.C. Art. 21.21-2, Sec. 4(a).)

21 Source Law

22 Sec. 4. (a) The commissioner is authorized to
23 hire additional employees and examiners as needed for
24 the effective enforcement of the provisions of this
25 Act.

26 Revised Law

27 Sec. 542.014. RULES. The commissioner shall adopt
28 reasonable rules as necessary to implement and augment the purposes
29 and provisions of this subchapter. (V.T.I.C. Art. 21.21-2, Sec.
30 8.)

31 Source Law

32 Sec. 8. The State Board of Insurance is
33 authorized and directed to issue such reasonable rules
34 and regulations as may be necessary to carry out the
35 various purposes and provisions of this Act, and in
36 augmentation thereof.

37 Revisor's Note
38 (End of Subchapter)

39 Section 9, V.T.I.C. Article 21.21-2, states that

1 the act does not apply to a person to whom it cannot
2 apply under the Texas or United States Constitution.
3 The revised law omits that provision as unnecessary.
4 Under general principles of constitutional law, a
5 Texas statute could not apply to a person the Texas or
6 United States Constitution does not allow the law to
7 apply to. The omitted law reads:

8 Sec. 9. This Act and law does not
9 apply to any insurer or other person to
10 whom, under the Constitution of the United
11 States or the Constitution of the State of
12 Texas, it cannot validly apply.

13 [Sections 542.015-542.050 reserved for expansion]

14 SUBCHAPTER B. PROMPT PAYMENT OF CLAIMS

15 Revised Law

16 Sec. 542.051. DEFINITIONS. In this subchapter:

17 (1) "Business day" means a day other than a Saturday,
18 Sunday, or holiday recognized by this state.

19 (2) "Claim" means a first-party claim that:

20 (A) is made by an insured or policyholder under
21 an insurance policy or contract or by a beneficiary named in the
22 policy or contract; and

23 (B) must be paid by the insurer directly to the
24 insured or beneficiary.

25 (3) "Claimant" means a person making a claim.

26 (4) "Notice of claim" means any written notification
27 provided by a claimant to an insurer that reasonably apprises the
28 insurer of the facts relating to the claim. (V.T.I.C. Art. 21.55,
29 Secs. 1(1), (2), (3), (5).)

30 Source Law

31 Art. 21.55

32 Sec. 1. In this article:

33 (1) "Claimant" means a person making a
34 claim.

35 (2) "Business day" means a day other than a
36 Saturday, Sunday, or holiday recognized by this state.

37 (3) "Claim" means a first party claim made
38 by an insured or a policyholder under an insurance
39 policy or contract or by a beneficiary named in the
40 policy or contract that must be paid by the insurer
41 directly to the insured or beneficiary.

1 (5) "Notice of claim" means any
2 notification in writing to an insurer, by a claimant,
3 that reasonably apprises the insurer of the facts
4 relating to the claim.

5 Revised Law

6 Sec. 542.052. APPLICABILITY OF SUBCHAPTER. This subchapter
7 applies to any insurer authorized to engage in business as an
8 insurance company or to provide insurance in this state, including:

9 (1) a stock life, health, or accident insurance
10 company;

11 (2) a mutual life, health, or accident insurance
12 company;

13 (3) a stock fire or casualty insurance company;

14 (4) a mutual fire or casualty insurance company;

15 (5) a Mexican casualty insurance company;

16 (6) a Lloyd's plan;

17 (7) a reciprocal or interinsurance exchange;

18 (8) a fraternal benefit society;

19 (9) a stipulated premium company;

20 (10) a nonprofit legal services corporation;

21 (11) a statewide mutual assessment company;

22 (12) a local mutual aid association;

23 (13) a local mutual burial association;

24 (14) an association exempt under Section 887.102;

25 (15) a nonprofit hospital, medical, or dental service
26 corporation, including a corporation subject to Chapter 842;

27 (16) a county mutual insurance company;

28 (17) a farm mutual insurance company;

29 (18) a risk retention group;

30 (19) a purchasing group;

31 (20) an eligible surplus lines insurer; and

32 (21) except as provided by Section 542.053(b), a
33 guaranty association operating under Article 21.28-C or 21.28-D.
34 (V.T.I.C. Art. 21.55, Sec. 1(4).)

1 Source Law

2 Sec. 1. In this article:

3 (4) "Insurer" means any insurer authorized
4 to do business as an insurance company or to provide
5 insurance in this state, including:

6 (A) a domestic or foreign, stock and
7 mutual, life, health, or accident insurance company;

8 (B) a domestic or foreign, stock or
9 mutual, fire and casualty insurance company;

10 (C) a Mexican casualty company;

11 (D) a domestic or foreign Lloyd's
12 plan insurer;

13 (E) a domestic or foreign reciprocal
14 or insurance exchange;

15 (F) a domestic or foreign fraternal
16 benefit society;

17 (G) a stipulated premium insurance
18 company;

19 (H) a nonprofit legal service
20 corporation;

21 (I) a statewide mutual assessment
22 company;

23 (J) a local mutual aid association;

24 (K) a local mutual burial
25 association;

26 (L) an association exempt under
27 Article 14.17 of this code;

28 (M) a nonprofit hospital, medical, or
29 dental service corporation, including a company
30 subject to Chapter 20 of this code;

31 (N) a county mutual insurance
32 company;

33 (O) a farm mutual insurance company;

34 (P) a risk retention group;

35 (Q) a purchase group;

36 (R) a surplus lines carrier; and

37 (S) a guaranty association created
38 and operating under Article 21.28-C or 21.28-D of this
39 code.

40 Revisor's Note

41 (1) Section 1(4), V.T.I.C. Article 21.55,
42 provides that "insurer" means any insurer authorized
43 to engage in business as an insurance company or to
44 provide insurance in this state, including certain
45 "domestic or foreign" insurers. The revised law omits
46 the reference to "domestic or foreign" as unnecessary.
47 The authority of the Texas Department of Insurance to
48 regulate domestic and foreign insurers is specified in
49 other provisions of the code and, because the revised
50 law applies to all insurers regulated by the
51 department, it is not necessary to distinguish between
52 domestic and foreign insurers in this section.

1 (2) Section 1(4), V.T.I.C. Article 21.55,
2 refers to an "insurance exchange," "purchase group,"
3 and "surplus lines carrier." The revised law
4 substitutes "interinsurance exchange" for "insurance
5 exchange" because that is the term used in Chapter 942
6 of this code, which governs reciprocal and
7 interinsurance exchanges, substitutes "purchasing
8 group" for "purchase group" because that is the term
9 used in V.T.I.C. Article 21.54, which regulates risk
10 retention groups and purchasing groups, and
11 substitutes "eligible surplus lines insurer" for
12 "surplus lines carrier" because that is the term used
13 in Chapter 981 of this code, which regulates surplus
14 lines insurance.

15 Revised Law

16 Sec. 542.053. EXCEPTION. (a) This subchapter does not
17 apply to:

- 18 (1) workers' compensation insurance;
- 19 (2) mortgage guaranty insurance;
- 20 (3) title insurance;
- 21 (4) fidelity, surety, or guaranty bonds;
- 22 (5) marine insurance other than inland marine
23 insurance governed by Article 5.53; or
- 24 (6) a guaranty association created and operating under
25 Chapter 2602.

26 (b) A guaranty association operating under Article 21.28-C
27 or 21.28-D is not subject to the damage provisions of Section
28 542.060.

29 (c) This subchapter does not apply to a health maintenance
30 organization except as provided by Section 1271.005(c).

31 (d) This subchapter does not apply to a claim governed by
32 Subchapter C, Chapter 1301. (V.T.I.C. Art. 21.55, Secs. 5(a), (b)
33 (part), (c).)

1 Source Law

2 Sec. 5. (a) This article does not apply to:
3 (1) workers' compensation insurance;
4 (2) mortgage guaranty insurance;
5 (3) title insurance;
6 (4) fidelity, surety, or guaranty bonds;
7 (5) marine insurance other than inland
8 marine insurance governed by Article 5.53 of this
9 code; or
10 (6) a guaranty association created and
11 operating under Article 9.48 of this code.
12 (b) A guaranty association created and
13 operating under Article 21.28-C or 21.28-D of this
14 code shall not be subject to the damage provisions
15 contained in Section 6 of this article. . . .
16 (c) This article does not apply to Chapter 20A
17 of this code except as provided in Section 9 of that
18 chapter. This article does not apply to a claim
19 governed by Section 3A, Article 3.70-3C, of this code.

20 Revisor's Note

21 Section 5(c), V.T.I.C. Article 21.55, refers to
22 the inapplicability of the article to "Chapter 20A of
23 this code." For clarity and convenience, the revised
24 law substitutes "health maintenance organization" for
25 "Chapter 20A of this code" because a health
26 maintenance organization is the type of entity
27 regulated under V.T.I.C. Chapter 20A, revised in
28 relevant part as Chapter 843 of this code.

29 Revised Law

30 Sec. 542.054. LIBERAL CONSTRUCTION. This subchapter shall
31 be liberally construed to promote the prompt payment of insurance
32 claims. (V.T.I.C. Art. 21.55, Sec. 8.)

33 Source Law

34 Sec. 8. This article shall be liberally
35 construed to promote its underlying purpose which is
36 to obtain prompt payment of claims made pursuant to
37 policies of insurance.

38 Revised Law

39 Sec. 542.055. RECEIPT OF NOTICE OF CLAIM. (a) Not later
40 than the 15th day or, if the insurer is an eligible surplus lines
41 insurer, the 30th business day after the date an insurer receives
42 notice of a claim, the insurer shall:

- 43 (1) acknowledge receipt of the claim;
44 (2) commence any investigation of the claim; and

1 (3) request from the claimant all items, statements,
2 and forms that the insurer reasonably believes, at that time, will
3 be required from the claimant.

4 (b) An insurer may make additional requests for information
5 if during the investigation of the claim the additional requests
6 are necessary.

7 (c) If the acknowledgment of receipt of a claim is not made
8 in writing, the insurer shall make a record of the date, manner, and
9 content of the acknowledgment. (V.T.I.C. Art. 21.55, Sec. 2.)

10 Source Law

11 Sec. 2. (a) Except as provided by Subsection
12 (d) of this section, an insurer shall, not later than
13 the 15th day after receipt of notice of a claim or the
14 30th business day if the insurer is an eligible surplus
15 lines insurer:

16 (1) acknowledge receipt of the claim;
17 (2) commence any investigation of the
18 claim; and

19 (3) request from the claimant all items,
20 statements, and forms that the insurer reasonably
21 believes, at that time, will be required from the
22 claimant. Additional requests may be made if during
23 the investigation of the claim such additional
24 requests are necessary.

25 (b) If the acknowledgment of the claim is not
26 made in writing, the insurer shall make a record of the
27 date, means, and content of the acknowledgment.

28 Revisor's Note

29 Section 2(a), V.T.I.C. Article 21.55, provides
30 that "[e]xcept as provided by Subsection (d) of this
31 section," an insurer shall perform certain acts after
32 receiving notice of a claim. Section 2 contains only
33 Subsections (a) and (b), and Subsection (b) does not
34 provide an exception to Subsection (a). Therefore,
35 the revised law omits the reference to an exception as
36 unnecessary.

37 Revised Law

38 Sec. 542.056. NOTICE OF ACCEPTANCE OR REJECTION OF CLAIM.

39 (a) Except as provided by Subsection (b) or (d), an insurer shall
40 notify a claimant in writing of the acceptance or rejection of a
41 claim not later than the 15th business day after the date the
42 insurer receives all items, statements, and forms required by the

1 insurer to secure final proof of loss.

2 (b) If an insurer has a reasonable basis to believe that a
3 loss resulted from arson, the insurer shall notify the claimant in
4 writing of the acceptance or rejection of the claim not later than
5 the 30th day after the date the insurer receives all items,
6 statements, and forms required by the insurer.

7 (c) If the insurer rejects the claim, the notice required by
8 Subsection (a) or (b) must state the reasons for the rejection.

9 (d) If the insurer is unable to accept or reject the claim
10 within the period specified by Subsection (a) or (b), the insurer,
11 within that same period, shall notify the claimant of the reasons
12 that the insurer needs additional time. The insurer shall accept or
13 reject the claim not later than the 45th day after the date the
14 insurer notifies a claimant under this subsection. (V.T.I.C.
15 Art. 21.55, Secs. 3(a), (b), (c), (d), (e).)

16 Source Law

17 Sec. 3. (a) Except as provided by Subsections
18 (b) and (d) of this section, an insurer shall notify a
19 claimant in writing of the acceptance or rejection of
20 the claim not later than the 15th business day after
21 the date the insurer receives all items, statements,
22 and forms required by the insurer, in order to secure
23 final proof of loss.

24 (b) If the insurer has a reasonable basis to
25 believe that the loss results from arson, the insurer
26 shall notify the claimant in writing of the acceptance
27 or rejection of the claim not later than the 30th day
28 after the date the insurer receives all items,
29 statements, and forms required by the insurer.

30 (c) If the insurer rejects the claim, the notice
31 required by Subsections (a) and (b) of this section
32 must state the reasons for the rejection.

33 (d) If the insurer is unable to accept or reject
34 the claim within the period specified by Subsection
35 (a) or (b) of this section, the insurer shall notify
36 the claimant, not later than the date specified under
37 Subsection (a) or (b), as applicable. The notice
38 provided under this subsection must give the reasons
39 the insurer needs additional time.

40 (e) Not later than the 45th day after the date an
41 insurer notifies a claimant under Subsection (d) of
42 this section, the insurer shall accept or reject the
43 claim.

44 Revised Law

45 Sec. 542.057. PAYMENT OF CLAIM. (a) Except as otherwise
46 provided by this section, if an insurer notifies a claimant under
47 Section 542.056 that the insurer will pay a claim or part of a

1 claim, the insurer shall pay the claim not later than the fifth
2 business day after the date notice is made.

3 (b) If payment of the claim or part of the claim is
4 conditioned on the performance of an act by the claimant, the
5 insurer shall pay the claim not later than the fifth business day
6 after the date the act is performed.

7 (c) If the insurer is an eligible surplus lines insurer, the
8 insurer shall pay the claim not later than the 20th business day
9 after the notice or the date the act is performed, as applicable.

10 (V.T.I.C. Art. 21.55, Sec. 4.)

11 Source Law

12 Sec. 4. If an insurer notifies a claimant that
13 the insurer will pay a claim or part of a claim under
14 Section 3 of this article, the insurer shall pay the
15 claim not later than the fifth business day after the
16 notice has been made. If payment of the claim or part
17 of the claim is conditioned on the performance of an
18 act by the claimant, the insurer shall pay the claim
19 not later than the fifth business day after the date
20 the act is performed. Surplus lines insurers shall pay
21 the claim not later than the twentieth business day
22 after the notice or date the act is performed.

23 Revisor's Note

24 Section 4, V.T.I.C. Article 21.55, refers to
25 "surplus lines insurers." The revised law substitutes
26 "eligible surplus lines insurer" because that is the
27 term used in Chapter 981 of this code, which regulates
28 surplus lines insurance.

29 Revised Law

30 Sec. 542.058. DELAY IN PAYMENT OF CLAIM. (a) Except as
31 otherwise provided, if an insurer, after receiving all items,
32 statements, and forms reasonably requested and required under
33 Section 542.055, delays payment of the claim for a period exceeding
34 the period specified by other applicable statutes or, if other
35 statutes do not specify a period, for more than 60 days, the insurer
36 shall pay damages and other items as provided by Section 542.060.

37 (b) This section does not apply in a case in which it is
38 found as a result of arbitration or litigation that a claim received
39 by an insurer is invalid and should not be paid by the insurer.

1 (V.T.I.C. Art. 21.55, Secs. 3(f), (g).)

2 Source Law

3 (f) Except as otherwise provided, if an insurer
4 delays payment of a claim following its receipt of all
5 items, statements, and forms reasonably requested and
6 required, as provided under Section 2 of this article,
7 for a period exceeding the period specified in other
8 applicable statutes or, in the absence of any other
9 specified period, for more than 60 days, the insurer
10 shall pay damages and other items as provided for in
11 Section 6 of this article.

12 (g) If it is determined as a result of
13 arbitration or litigation that a claim received by an
14 insurer is invalid and therefore should not be paid by
15 the insurer, the requirements of Subsection (f) of
16 this section shall not apply in such case.

17 Revised Law

18 Sec. 542.059. EXTENSION OF DEADLINES. (a) A court may
19 grant a request by a guaranty association for an extension of the
20 periods under this subchapter on a showing of good cause and after
21 reasonable notice to policyholders.

22 (b) In the event of a weather-related catastrophe or major
23 natural disaster, as defined by the commissioner, the
24 claim-handling deadlines imposed under this subchapter are
25 extended for an additional 15 days. (V.T.I.C. Art. 21.55, Secs.
26 5(b) (part), (d).)

27 Source Law

28 (b) . . . A guaranty association may receive
29 an extension of the time periods under this article
30 from a court of competent jurisdiction upon good cause
31 shown and after reasonable notice to policyholders.

32 (d) In the event of a weather-related
33 catastrophe or major natural disaster, as defined by
34 the State Board of Insurance, the claim-handling
35 deadlines imposed under this article are extended for
36 an additional 15 days.

37 Revised Law

38 Sec. 542.060. LIABILITY FOR VIOLATION OF SUBCHAPTER. (a)
39 If an insurer that is liable for a claim under an insurance policy
40 is not in compliance with this subchapter, the insurer is liable to
41 pay the holder of the policy or the beneficiary making the claim
42 under the policy, in addition to the amount of the claim, interest
43 on the amount of the claim at the rate of 18 percent a year as
44 damages, together with reasonable attorney's fees.

1 (b) If a suit is filed, the attorney's fees shall be taxed as
2 part of the costs in the case. (V.T.I.C. Art. 21.55, Sec. 6.)

3 Source Law

4 Sec. 6. In all cases where a claim is made
5 pursuant to a policy of insurance and the insurer
6 liable therefor is not in compliance with the
7 requirements of this article, such insurer shall be
8 liable to pay the holder of the policy, or the
9 beneficiary making a claim under the policy, in
10 addition to the amount of the claim, 18 percent per
11 annum of the amount of such claim as damages, together
12 with reasonable attorney fees. If suit is filed, such
13 attorney fees shall be taxed as part of the costs in
14 the case.

15 Revised Law

16 Sec. 542.061. REMEDIES NOT EXCLUSIVE. The remedies
17 provided by this subchapter are in addition to any other remedy or
18 procedure provided by law or at common law. (V.T.I.C. Art. 21.55,
19 Sec. 7.)

20 Source Law

21 Sec. 7. The provisions of this article are not
22 exclusive. The remedies provided herein are in
23 addition to any other remedy or procedure provided by
24 any other law or at common law.

25 [Sections 542.062-542.100 reserved for expansion]

26 SUBCHAPTER C. PROVIDING CERTAIN CLAIMS INFORMATION ON REQUEST

27 Revised Law

28 Sec. 542.101. REQUEST BY NAMED INSURED UNDER LIABILITY
29 INSURANCE POLICY. (a) In this section, "liability insurance"
30 means:

- 31 (1) general liability insurance;
32 (2) professional liability insurance, including
33 medical professional liability insurance;
34 (3) commercial automobile liability insurance; and
35 (4) the liability portion of commercial multiperil
36 insurance.

37 (b) On written request of a named insured under a liability
38 insurance policy, the insurer that wrote the policy shall provide
39 to the insured information relating to the disposition of a claim
40 filed under the policy. The information must include:

- 1 (1) the name of each claimant;
- 2 (2) details relating to:
- 3 (A) the amount paid on the claim;
- 4 (B) settlement of the claim; or
- 5 (C) judgment on the claim;
- 6 (3) details as to how the claim, settlement, or
- 7 judgment is to be paid; and
- 8 (4) any other information required by rule of the
- 9 commissioner that the commissioner considers necessary to
- 10 adequately inform an insured with regard to any claim under a
- 11 liability insurance policy.
- 12 (c) A request for information under this section must be
- 13 transmitted to the insurer not later than six months after the date
- 14 of disposition of the claim. (V.T.I.C. Art. 21.59, Secs. (a), (b),
- 15 (c), (f).)

16 Source Law

- 17 Art. 21.59. (a) In this article, "liability
- 18 insurance" means the following types of insurance:
- 19 (1) general liability;
- 20 (2) medical professional liability;
- 21 (3) professional liability other than
- 22 medical professional liability;
- 23 (4) commercial automobile liability; and
- 24 (5) the liability portion of commercial
- 25 multiperil coverage.
- 26 (b) On written request of a named insured under
- 27 a liability insurance policy, the insurer that wrote
- 28 the policy shall provide to the insured information
- 29 relating to the disposition of a claim filed under the
- 30 policy. The request must be transmitted to the insurer
- 31 within six months from the date of disposition of the
- 32 claim.
- 33 (c) The information supplied to an insured
- 34 making a request under Subsection (b) of this article
- 35 must include:
- 36 (1) the name of each claimant;
- 37 (2) details relating to the amount paid on
- 38 the claim, settlement of the claim, or judgment on the
- 39 claim;
- 40 (3) details as to how the claim,
- 41 settlement, or judgment is to be paid; and
- 42 (4) any other information required by rule
- 43 of the commissioner.
- 44 (f) The commissioner, by rule, may require
- 45 information in addition to that required by Subsection
- 46 (c) of this article that the commissioner considers
- 47 necessary to adequately inform an insured with regard
- 48 to any claim under a liability insurance policy.

1 Revised Law

2 Sec. 542.102. REQUEST BY POLICYHOLDER UNDER PROPERTY AND
3 CASUALTY INSURANCE POLICY. (a) On written request of a
4 policyholder, an insurer that writes property and casualty
5 insurance in this state shall provide the policyholder with a list
6 of claims charged against the policy and payments made on each
7 claim.

8 (b) This section does not apply to a workers' compensation
9 insurance policy subject to Article 5.65A. (V.T.I.C. Art. 21.59,
10 Sec. (d).)

11 Source Law

12 (d) Each insurer that writes property and
13 casualty insurance in this state, on written request
14 of the policyholder, shall provide the policyholder
15 with a list of claims charged against the policy and
16 payments made on each claim. This subsection does not
17 apply to a workers' compensation insurance policy
18 subject to Article 5.65A of this code.

19 Revised Law

20 Sec. 542.103. DEADLINE FOR PROVIDING REQUESTED
21 INFORMATION. (a) An insurer shall provide the information
22 requested under this subchapter in writing not later than the 30th
23 day after the date the insurer receives the request for the
24 information.

25 (b) For purposes of this section, information is considered
26 to be provided on the date the information is deposited with the
27 United States Postal Service or is personally delivered. (V.T.I.C.
28 Art. 21.59, Sec. (e).)

29 Source Law

30 (e) The insurer shall provide the information
31 requested under this article in writing not later than
32 the 30th day after the date on which the written
33 request is received by the insurer. The information is
34 considered to be provided on the date that the
35 information is received by the United States Postal
36 Service or personally delivered.

37 Revisor's Note

38 Section (e), V.T.I.C. Article 21.59, refers to a
39 "written request" for information. The revised law
40 omits the reference to "written" as duplicative of

1 Sections (b) and (d), V.T.I.C. Article 21.59, revised
2 as Sections 542.101(b) and 542.102(a), which require
3 the requests for information to be in writing.

4 Revised Law

5 Sec. 542.104. RULES. The commissioner may by rule
6 prescribe forms for requesting information and for providing
7 requested information under this subchapter. (V.T.I.C. Art. 21.59,
8 Sec. (g).)

9 Source Law

10 (g) The commissioner may adopt rules providing
11 the form for requests to an insurer and for information
12 supplied by an insurer under this article.

13 [Sections 542.105-542.150 reserved for expansion]

14 SUBCHAPTER D. NOTICE OF SETTLEMENT OF CLAIM UNDER CASUALTY
15 INSURANCE POLICY

16 Revised Law

17 Sec. 542.151. APPLICABILITY OF SUBCHAPTER. This
18 subchapter applies only to the settlement of a claim under a
19 casualty insurance policy that is delivered, issued for delivery,
20 or renewed in this state, including a policy written by:

- 21 (1) a county mutual insurance company;
22 (2) a Lloyd's plan;
23 (3) an eligible surplus lines insurer; or
24 (4) a reciprocal or interinsurance exchange.

25 (V.T.I.C. Art. 21.56, Sec. (a) (part).)

26 Source Law

27 Art. 21.56. (a) This article applies only to
28 settlement of a claim under a policy of casualty
29 insurance delivered, issued for delivery, or renewed
30 in this state, including a policy written by a county
31 mutual insurance company, Lloyd's plan company,
32 surplus lines insurer, or a reciprocal or
33 interinsurance exchange. . . .

34 Revisor's Note

35 Section (a), V.T.I.C. Article 21.56, refers to a
36 "surplus lines insurer." The revised law substitutes
37 "eligible surplus lines insurer" for "surplus lines
38 insurer" because that is the term used in Chapter 981

1 of this code, which regulates surplus lines insurance.

2 Revised Law

3 Sec. 542.152. EXCEPTION. This subchapter does not apply
4 to:

5 (1) a casualty insurance policy that requires the
6 insured's consent to settle a claim against the insured;

7 (2) fidelity, surety, or guaranty bonds; or

8 (3) marine insurance other than inland marine
9 insurance governed by Article 5.53. (V.T.I.C. Art. 21.56, Secs.
10 (a) (part), (e).)

11 Source Law

12 (a) . . . This article does not apply to a
13 casualty policy that requires the insured's consent to
14 settlement of a claim against the insured or to
15 fidelity, surety, or guaranty bonds.

16 (e) The provisions of this article shall not
17 apply to marine insurance other than inland marine
18 insurance governed by Article 5.53 of this code.

19 Revised Law

20 Sec. 542.153. NOTICE REQUIRED. (a) Not later than the
21 10th day after the date an initial offer to settle a claim against a
22 named insured under a casualty insurance policy issued to the
23 insured is made, the insurer shall notify the insured in writing of
24 the offer.

25 (b) Not later than the 30th day after the date a claim
26 against a named insured under a casualty insurance policy issued to
27 the insured is settled, the insurer shall notify the insured in
28 writing of the settlement. (V.T.I.C. Art. 21.56, Secs. (b), (c).)

29 Source Law

30 (b) An insurer shall notify the named insured in
31 writing of initial offer to compromise or settle a
32 claim against the insured made under a casualty policy
33 issued to the named insured. The notice shall be given
34 not later than the 10th day after the date on which the
35 offer is made.

36 (c) An insurer shall notify the named insured in
37 writing of any settlement of a claim against the
38 insured made under a casualty policy issued to the
39 named insured. The notice shall be given not later than
40 the 30th day after the date of the settlement.

1 Revisor's Note

2 Section (b), V.T.I.C. Article 21.56, refers to an
3 "offer to compromise or settle a claim." The revised
4 law omits the reference to "compromise" because its
5 meaning is included within the meaning of "settle."

6 Revised Law

7 Sec. 542.154. RULES. The commissioner may adopt rules to
8 implement this subchapter. (V.T.I.C. Art. 21.56, Sec. (d).)

9 Source Law

10 (d) The board may adopt rules to implement this
11 article.

12 [Sections 542.155-542.200 reserved for expansion]

13 SUBCHAPTER E. COLLECTION FROM THIRD PARTIES UNDER CERTAIN
14 AUTOMOBILE INSURANCE POLICIES

15 Revised Law

16 Sec. 542.201. PURPOSE. This subchapter is intended to
17 encourage insurers to take appropriate and necessary steps to
18 collect from third parties or the insurers of the third parties.
19 (V.T.I.C. Art. 21.79G, Sec. (e) (part).)

20 Source Law

21 (e) This article is intended to encourage
22 insurers to take appropriate and necessary steps to
23 collect from third parties or their insurers. . . .

24 Revised Law

25 Sec. 542.202. DEFINITION. In this subchapter, "action"
26 includes taking various actions such as reasonable and diligent
27 collection efforts, mediation, arbitration, and litigation against
28 a responsible third party or the third party's insurer. (V.T.I.C.
29 Art. 21.79G, Sec. (e) (part).)

30 Source Law

31 (e) . . . As used in this article, the phrase
32 "bring an action" is intended to include various
33 courses of action such as reasonable and diligent
34 collection efforts, mediation, arbitration, or
35 litigation against responsible third parties or their
36 insurers.

37 Revised Law

38 Sec. 542.203. APPLICABILITY OF SUBCHAPTER. This

1 subchapter applies to any insurer that delivers, issues for
2 delivery, or renews in this state a private passenger automobile
3 insurance policy, including a reciprocal or interinsurance
4 exchange, mutual insurance company, association, Lloyd's plan, or
5 other insurer. (V.T.I.C. Art. 21.79G, Sec. (a).)

6 Source Law

7 Art. 21.79G. (a) This article applies to any
8 insurer who delivers, issues for delivery, or renews a
9 private passenger automobile policy of insurance in
10 this state, including an interinsurance exchange,
11 mutual, reciprocal, association, Lloyd's, or other
12 insurer.

13 Revised Law

14 Sec. 542.204. ACTION TO RECOVER DEDUCTIBLE. (a)
15 Notwithstanding any other provision of this code and except as
16 provided by Subsection (b), if an insurer is liable to an insured
17 for a claim that is subject to a deductible payable by the insured
18 and a third party may be liable to the insurer or the insured for the
19 amount of the deductible, the insurer shall:

20 (1) take action to recover the deductible against the
21 third party not later than the first anniversary of the date the
22 insured's claim is paid; or

23 (2) pay the amount of the deductible to the insured.

24 (b) An insurer is not required to take action or pay the
25 amount of the deductible as required by Subsection (a) if, not later
26 than the earlier of the first anniversary of the date the insured's
27 claim is paid or the 90th day before the date the statute of
28 limitations for a negligence action expires, the insurer:

29 (1) notifies the insured in writing that the insurer
30 does not intend to take further collection actions against the
31 third party; and

32 (2) authorizes the insured to take further collection
33 actions.

34 (c) This section applies regardless of whether the third
35 party who may be liable for the amount of the deductible is insured
36 or uninsured. (V.T.I.C. Art. 21.79G, Secs. (b), (c), (d).)

1 Source Law

2 (b) Notwithstanding any other provision of this
3 code, and except as provided by Subsection (c) of
4 this article, if an insurer is liable to an insured for
5 a claim, and such claim is subject to a deductible
6 payable by the insured, and a third party may be liable
7 to the insurer or the insured for the amount of the
8 deductible, the insurer shall bring an action to
9 recover the deductible against the third party not
10 later than 12 months after payment of its insured's
11 claim or pay the amount of the deductible to the
12 insured.

13 (c) Subsection (b) of this article does not
14 apply if, not later than the earlier of 12 months after
15 the date the insured's claim is paid or 90 days prior to
16 the expiration of the statute of limitations for
17 negligence actions, the insurer notifies the insured
18 in writing that the insurer does not intend to pursue
19 further collection actions against the third party and
20 authorizes the insured to pursue further collection
21 actions.

22 (d) This article applies whether the third party
23 who may be liable for the amount of the deductible is
24 insured or uninsured.

25 Revised Law

26 Sec. 542.205. ENFORCEMENT; RULES. The commissioner may
27 enforce this subchapter and adopt and enforce reasonable rules
28 necessary to accomplish the purposes of this subchapter. (V.T.I.C.
29 Art. 21.79G, Sec. (f).)

30 Source Law

31 (f) The commissioner shall have authority to
32 enforce this article and is authorized to promulgate
33 and enforce reasonable rules and regulations as
34 necessary for the accomplishment of the purposes of
35 this article.

36 CHAPTER 543. PROHIBITED PRACTICES RELATED TO POLICY OR CERTIFICATE
37 OF MEMBERSHIP

38 SUBCHAPTER A. PROHIBITIONS

39 Sec. 543.001. MISREPRESENTATION PROHIBITED 300
40 Sec. 543.002. CONTRACT EXPRESSED IN POLICY ONLY. 303
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42 Sec. 543.004. SHARING OF OR PARTICIPATION IN SPECIAL FUND
43 PROHIBITED 304

44 [Sections 543.005-543.050 reserved for expansion]

45 SUBCHAPTER B. ENFORCEMENT; PENALTY

46 Sec. 543.051. SUSPENSION OR REVOCATION OF CERTIFICATE, CHARTER,
47 PERMIT, OR LICENSE 305

1 Sec. 543.052. CRIMINAL PENALTY 305

2 CHAPTER 543. PROHIBITED PRACTICES RELATED TO POLICY

3 OR CERTIFICATE OF MEMBERSHIP

4 SUBCHAPTER A. PROHIBITIONS

5 Revised Law

6 Sec. 543.001. MISREPRESENTATION PROHIBITED. (a) In this
7 section, "life, health, or casualty insurer" includes a corporation
8 operating on a cooperative or assessment plan, a mutual insurance
9 company, a fraternal benefit society, and any other society or
10 association authorized to issue an insurance policy in this state.

11 (b) A life, health, or casualty insurer, an officer,
12 director, agent, or representative of that insurer, or any other
13 person, corporation, or copartnership may not:

14 (1) issue, circulate, or cause or permit to be issued
15 or circulated any statement, including an illustration or estimate,
16 that misrepresents:

17 (A) the terms of a policy or certificate of
18 membership issued by a life, health, or casualty insurer;

19 (B) other benefits or advantages provided by the
20 policy or certificate; or

21 (C) the dividends or share of surplus to be
22 received on the policy or certificate;

23 (2) use a name or title of a policy, policy class,
24 certificate of membership, or certificate class that misrepresents
25 the policy, certificate, or class; or

26 (3) make a misleading representation or incomplete
27 comparison of a policy or certificate of membership to an insured or
28 member for the purpose of inducing or tending to induce the insured
29 or member to forfeit, surrender, or allow the lapse of the insurance
30 or membership.

31 (c) The commissioner may adopt and enforce reasonable rules
32 as provided by Subchapter I, Chapter 541, to accomplish the
33 purposes of Subsection (b)(1) as those purposes relate to life
34 insurance companies. (V.T.I.C. Art. 21.20; Art. 21.21, Sec. 13

1 (part); Art. 21.21A, Sec. 2.)

2 Source Law

3 Art. 21.20. No life insurance company doing
4 business in this State, and no officer, director or
5 agent thereof, shall issue or circulate, or cause or
6 permit to be issued or circulated, any estimate,
7 illustration, circular or statement of any sort
8 misrepresenting the terms of any policy issued by it,
9 or benefits or advantages to be promised thereby, or
10 the dividends or share of surplus to be received
11 thereon.

12 [Art. 21.21]

13 Sec. 13. (a) The State Board of Insurance is
14 authorized to promulgate and may promulgate and
15 enforce reasonable rules and regulations and may order
16 such provision as is necessary in the accomplishment
17 of the purposes of [this Article] and Article 21.20[,
18 including, but not limited to, such express provision
19 within the purposes of these Articles as it deems
20 necessary or as is required to affect necessary
21 uniformity with the laws of other states or the United
22 States or in conformity with the adopted procedures of
23 the National Association of Insurance Commissioners
24 notwithstanding any previous definition or
25 interpretation of terms used in these Articles had in
26 or derived from the common law or other statutory law
27 of this state.

28 (b) A petition may be submitted to the Board to
29 adopt, amend, or repeal a regulation. The petition
30 must be signed by 100 interested persons and supported
31 by evidence that a particular act or practice has been
32 or could be false, misleading or deceptive to the
33 insurance buying public, or that an act or practice
34 declared to be false, misleading, or deceptive by a
35 regulation of the Board is not in fact false,
36 misleading, or deceptive. Within 30 days after
37 receipt of the petition the Board must either deny the
38 petition or initiate hearing proceedings under this
39 section.

40 (c) On denial of the petition the Board must
41 state the reason or reasons for denial in writing.
42 Denial is expressly authorized if the action sought by
43 the petition would destroy uniformity with the laws of
44 other states or of the United States or would not be in
45 conformity with the adopted procedures of the National
46 Association of Insurance Commissioners.

47 (d) If in response to the petition the Board
48 determines to hold a hearing, such hearing shall be
49 open to the public and any person may present
50 testimony, data, or other information in writing or
51 orally to the Board regarding the acts or practices
52 under consideration.

53 (e) A person aggrieved by the denial of the
54 hearing under Subsection (b) of this section or by the
55 adoption, amendment, or repeal of a regulation or
56 failure to issue a regulation under this section, may
57 file a petition in a district court of Travis County
58 for a declaratory judgment on the validity or
59 applicability of a regulation adopted, amended, or
60 repealed under this section or on the denial of a
61 hearing under Subsection (b) of this section. The
62 Board shall be made a party to the action. In a suit
63 under this subsection the district court may issue
64 injunctions.

1 (f) The action of the Board in adopting,
2 amending, repealing, or failing to adopt a regulation
3 or denying a hearing may be invalidated only if it is
4 found that it:

5 (1) violates a constitutional or state
6 statutory provision;

7 (2) exceeds the statutory authority of the
8 Board;

9 (3) is arbitrary or capricious or
10 characterized by abuse of discretion or unwarranted
11 exercise of discretion;

12 (4) is so vague that it does not establish
13 sufficiently definite standards with which conduct can
14 be conformed;

15 (5) is made on unlawful procedure; or

16 (6) is clearly erroneous in view of the
17 reliable, probative, and substantial evidence in the
18 whole record as submitted.]

19 [Art. 21.21A]

20 Sec. 2. No life, health, or casualty insurance
21 corporation including corporations operating on the
22 cooperative or assessment plan, mutual insurance
23 companies, and fraternal benefit associations or
24 societies, and any other societies or associations
25 authorized to issue insurance policies in this state,
26 and no officer, director, representative, or agent
27 therefor or thereof, or any other person, corporation,
28 or copartnership may issue or circulate or cause or
29 permit to be issued or circulated any illustrated
30 circular or statement of any sort misrepresenting the
31 terms of any policy issued by any such corporation or
32 association or any certificate of membership issued by
33 any such society or corporation, or other benefits or
34 advantages permitted thereby, or any misleading
35 statement of the dividends or share of surplus to be
36 received thereon, or may use any name or title of any
37 policy or class of policy or class of policies, or
38 certificate of membership or class of such certificate
39 misrepresenting the true nature thereof. Nor may any
40 such corporation, society, or association, or officer,
41 director, agent, or representative thereof, or any
42 other person, make any misleading representations or
43 incomplete comparisons of policies or certificates of
44 membership to any person insured in such corporation,
45 association, or society, or member thereof, for the
46 purpose of inducing or tending to induce such person to
47 lapse, forfeit, or surrender said insurance or
48 membership therein.

49 Revisor's Note

50 V.T.I.C. Article 21.20 states that certain
51 entities may not "issue or circulate, or cause or
52 permit to be issued or circulated, any
53 [misrepresentative] estimate, illustration, circular
54 or statement of any sort." Section 2, V.T.I.C. Article
55 21.21A, states that certain entities may not "issue or
56 circulate or cause or permit to be issued or circulated
57 any [misrepresentative] illustrated circular or

1 statement of any sort." The revised law omits the
2 references to "circular" as redundant with respect to
3 "circulate[,] or cause or permit to be
4 . . . circulated."

5 Revised Law

6 Sec. 543.002. CONTRACT EXPRESSED IN POLICY ONLY. An
7 insurer or an agent of an insurer may not make an insurance contract
8 or an agreement relating to an insurance contract other than as
9 expressed in the policy issued in connection with the contract.
10 (V.T.I.C. Art. 21.21A, Sec. 1 (part).)

11 Source Law

12 Sec. 1. No insurer or agent thereof may make any
13 contract of insurance or agreement as to such contract
14 other than as expressed in the policy issued thereon,
15

16 Revised Law

17 Sec. 543.003. THING OF VALUE NOT SPECIFIED IN POLICY. An
18 insurer or an officer, agent, or representative of an insurer may
19 not:

20 (1) directly or indirectly pay, allow, or give or
21 offer to pay, allow, or give as an inducement to insurance a thing
22 of value or other inducement that is not specified in the policy,
23 including:

24 (A) a rebate of premium payable on the policy;

25 (B) a special favor or advantage in the dividends
26 or other benefits to accrue on the policy; or

27 (C) paid employment or a contract for service; or

28 (2) give, sell, or purchase or offer to give, sell, or
29 purchase as an inducement to insurance or in connection with
30 insurance a thing of value that is not specified in the policy,
31 including:

32 (A) stocks, bonds, or other securities of an
33 insurer or other corporation, association, or partnership; or

34 (B) dividends or profits to accrue on the stocks,
35 bonds, or other securities of an insurer or other corporation,

1 association, or partnership. (V.T.I.C. Art. 21.21A, Sec. 1
2 (part).)

3 Source Law

4 Sec. 1. . . . nor may any such insurer or any
5 officer, agent, solicitor or representative thereof,
6 pay, allow or give, or offer to pay, allow or give,
7 directly or indirectly as an inducement to insurance,
8 any rebate of premium payable on the policy, or any
9 special favor or advantage in the dividends or other
10 benefits to accrue thereon or any paid employment or
11 contract for service of any kind, or any thing of value
12 or inducement whatever, not specified in the policy;
13 or give, sell or purchase, or offer to give, sell or
14 purchase, as an inducement to insurance or in
15 connection therewith, any stocks, bonds or other
16 securities of any insurer or other corporation,
17 association or partnership, or any dividends or
18 profits to accrue thereon, or anything of value
19 whatsoever not specified in the policy,

20 Revisor's Note

21 Section 1, V.T.I.C. Article 21.21A, refers to an
22 "officer, agent, solicitor or representative."
23 Throughout this subchapter, the revised law omits the
24 reference to "solicitor" because that term, as it
25 relates to a particular type of person engaged in the
26 business of insurance, was eliminated by Chapter 703,
27 Acts of the 77th Legislature, Regular Session, 2001,
28 and a person who performs the duties formerly
29 performed by a solicitor is now regulated as an
30 "agent."

31 Revised Law

32 Sec. 543.004. SHARING OF OR PARTICIPATION IN SPECIAL FUND
33 PROHIBITED. An insurer or an officer, agent, or representative of
34 an insurer may not issue a policy that contains a special or board
35 contract or similar provision by the terms of which the policy will
36 share or participate in a special fund derived from a tax or a
37 charge against any portion of the premium on another policy.
38 (V.T.I.C. Art. 21.21A, Sec. 1 (part).)

39 Source Law

40 Sec. 1. . . . nor may any such insurer or any
41 officer, agent, solicitor or representative
42 thereof . . . or issue any policy containing any
43 special or board contract or similar provision by the

1 terms of which said policy will share or participate in
2 any special fund derived from a tax or a charge against
3 any portion of the premium on any other policy.

4 [Sections 543.005-543.050 reserved for expansion]

5 SUBCHAPTER B. ENFORCEMENT; PENALTY

6 Revised Law

7 Sec. 543.051. SUSPENSION OR REVOCATION OF CERTIFICATE,
8 CHARTER, PERMIT, OR LICENSE. (a) On a hearing, the commissioner
9 may suspend or revoke the certificate, charter, permit, or license
10 to engage in the business of insurance of a society, association,
11 corporation, or person that violates Subchapter A.

12 (b) The commissioner must give 10 days' notice of the
13 hearing by certified mail to the society, association, corporation,
14 or person. (V.T.I.C. Art. 21.21A, Sec. 4.)

15 Source Law

16 Sec. 4. The commissioner, upon giving 10 days'
17 notice of hearing by certified mail, and upon hearing,
18 may suspend or cancel the certificate, charter,
19 permit, or license to engage in the business of
20 insurance of any society, association, corporation, or
21 person violating the provisions of this Article.

22 Revisor's Note

23 Section 4, V.T.I.C. Article 21.21A, enables the
24 commissioner of insurance to "cancel" the certificate,
25 charter, permit, or license of certain entities. The
26 revised law substitutes "revoke" for "cancel" because,
27 in context, the terms are synonymous, and "revoke" is
28 more frequently used.

29 Revised Law

30 Sec. 543.052. CRIMINAL PENALTY. (a) A person commits an
31 offense if the person violates Subchapter A.

32 (b) An offense under this section is a Class A misdemeanor.

33 (c) The penalty provided by this section is in addition to
34 any other penalty specifically provided by law. (V.T.I.C. Art.
35 21.21A, Sec. 3.)

36 Source Law

37 Sec. 3. If any person violates any of the
38 provisions of this Article, the person shall, in
39 addition to any other penalty specifically provided,

1 be guilty of a Class A misdemeanor.

2 CHAPTER 544. PROHIBITED DISCRIMINATION

3 SUBCHAPTER A. GENERAL PROHIBITIONS AGAINST DISCRIMINATION BY AN
4 INSURER OR HEALTH MAINTENANCE ORGANIZATION

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9 [Sections 544.005-544.050 reserved for expansion]

10 SUBCHAPTER B. OTHER GENERAL PROHIBITIONS AGAINST
11 DISCRIMINATION BY INSURERS

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16 [Sections 544.055-544.100 reserved for expansion]

17 SUBCHAPTER C. ENGLISH FLUENCY

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21 [Sections 544.104-544.150 reserved for expansion]

22 SUBCHAPTER D. FAMILY VIOLENCE

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28	Sec. 544.156.	HEALTH BENEFIT PLAN ISSUER OR LIFE INSURER NOT 29 LIABLE FOR DEATH OR BODILY INJURY	329
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31	Sec. 544.158.	UNFAIR OR DECEPTIVE ACT OR PRACTICE	330
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32 [Sections 544.159-544.200 reserved for expansion]

33 SUBCHAPTER E. FIBROCYSTIC BREAST CONDITION

34	Sec. 544.201.	DEFINITION	330
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1 Sec. 544.202. PROHIBITION 331
2 Sec. 544.203. UNFAIR OR DECEPTIVE ACT OR PRACTICE 332
3 Sec. 544.204. PAYMENT FOR DISEASE NOT REQUIRED 333
4 [Sections 544.205-544.250 reserved for expansion]
5 SUBCHAPTER F. CHURCH PROPERTY
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7 Sec. 544.252. APPLICABILITY OF SUBCHAPTER 334
8 Sec. 544.253. PROHIBITION 334
9 Sec. 544.254. UNFAIR OR DECEPTIVE ACT OR PRACTICE 335

10 CHAPTER 544. PROHIBITED DISCRIMINATION

11 SUBCHAPTER A. GENERAL PROHIBITIONS AGAINST DISCRIMINATION BY AN
12 INSURER OR HEALTH MAINTENANCE ORGANIZATION

13 Revised Law

14 Sec. 544.001. APPLICABILITY OF SUBCHAPTER. This
15 subchapter applies to:

16 (1) any legal entity engaged in the business of
17 insurance in this state, including:

- 18 (A) a capital stock insurance company;
- 19 (B) a mutual insurance company;
- 20 (C) a title insurance company;
- 21 (D) a fraternal benefit society;
- 22 (E) a local mutual aid association;
- 23 (F) a statewide mutual assessment company;
- 24 (G) a county mutual insurance company;
- 25 (H) a Lloyd's plan;
- 26 (I) a reciprocal or interinsurance exchange;
- 27 (J) a stipulated premium company;
- 28 (K) a group hospital service corporation;
- 29 (L) a farm mutual insurance company;
- 30 (M) a risk retention group;
- 31 (N) an eligible surplus lines insurer; and
- 32 (O) an agent, broker, adjuster, or life and

33 health insurance counselor; and

34 (2) a health maintenance organization. (V.T.I.C. Art.

1 21.21-6, Sec. 2, as added Acts 74th Leg., R.S., Ch. 415.)

2 Source Law

3 Sec. 2. This article shall apply to any legal
4 entity engaged in the business of insurance in this
5 state, including:

- 6 (a) a capital stock company;
- 7 (b) a mutual company;
- 8 (c) a title insurance company;
- 9 (d) a fraternal benefit society;
- 10 (e) a local mutual aid association;
- 11 (f) a statewide mutual assessment company;
- 12 (g) a county mutual insurance company;
- 13 (h) a Lloyd's plan company;
- 14 (i) a reciprocal or interinsurance exchange;
- 15 (j) a stipulated premium insurance company;
- 16 (k) a group hospital service company;
- 17 (l) a health maintenance organization;
- 18 (m) a farm mutual insurance company;
- 19 (n) a risk retention group;
- 20 (o) a surplus lines carrier; and
- 21 (p) agents, brokers, adjusters, and life
22 insurance counselors.

23 Revisor's Note

24 (1) Section 2, V.T.I.C. Article 21.21-6, as
25 added by Chapter 415, Acts of the 74th Legislature,
26 Regular Session, 1995, provides that the article
27 applies to a legal entity "engaged in the business of
28 insurance," including certain listed entities.
29 Included among the listed entities is a "health
30 maintenance organization," which is not a traditional
31 insurer. The revised law is drafted accordingly.
32 Similar changes are made throughout this subchapter.

33 (2) Section 2, V.T.I.C. Article 21.21-6, as
34 added by Chapter 415, Acts of the 74th Legislature,
35 Regular Session, 1995, refers to "life insurance
36 counselors." The revised law substitutes "life and
37 health insurance counselor" because that is the term
38 used in Chapter 4052 to refer to that type of insurance
39 professional. The term was changed from "life
40 insurance counselor" to "life and health insurance
41 counselor" by Chapter 1530, Acts of the 76th
42 Legislature, Regular Session, 1999.

1 Revised Law

2 Sec. 544.002. UNFAIR DISCRIMINATION. (a) A person may not
3 refuse to insure or provide coverage to an individual, refuse to
4 continue to insure or provide coverage to an individual, limit the
5 amount, extent, or kind of coverage available for an individual, or
6 charge an individual a rate that is different from the rate charged
7 to other individuals for the same coverage because of the
8 individual's:

9 (1) race, color, religion, or national origin;

10 (2) age, gender, marital status, or geographic
11 location; or

12 (3) disability or partial disability.

13 (b) Subsection (a)(2) does not prohibit an insurer or health
14 maintenance organization from considering marital status in
15 defining persons eligible for dependent benefits.

16 (c) Subsection (a) does not prevent requirements to provide
17 title insurance coverage relating to possible community,
18 homestead, or other marital rights in land. (V.T.I.C. Art.
19 21.21-6, Secs. 1, 3, 4(e) (part), as added Acts 74th Leg., R.S., Ch.
20 415.)

21 Source Law

22 Art. 21.21-6

23 Sec. 1. No person shall engage in any practice of
24 unfair discrimination which is defined in this article
25 or is determined pursuant to this article to be a
26 practice of unfair discrimination in the business of
27 insurance.

28 Sec. 3. "Unfair discrimination" means:

29 (a) Refusing to insure; refusing to
30 continue to insure; limiting the amount, extent, or
31 kind of coverage available; or charging an individual
32 a different rate for the same coverage because of race,
33 color, religion, or national origin;

34 (b) Refusing to insure; refusing to
35 continue to insure; limiting the amount, extent, or
36 kind of coverage available; or charging an individual
37 a different rate for the same coverage because of the
38 age, gender, marital status, or geographic location of
39 the individual; however, nothing in this paragraph
40 shall prohibit an insurer from taking marital status
41 into account for the purpose of defining persons
42 eligible for dependent benefits;

43 (c) Refusing to insure; refusing to
44 continue to insure; limiting the amount, extent, or
45 kind of coverage; or charging an individual a

1 different rate for the same coverage because of
2 disability or partial disability.

3 [Sec. 4]
4 (e) . . . This article shall not prevent
5 requirements to provide title insurance coverage
6 relating to possible community, homestead, or other
7 martial rights in land.

8 Revisor's Note

9 (1) Section 1, V.T.I.C. Article 21.21-6, as
10 added by Chapter 415, Acts of the 74th Legislature,
11 Regular Session, 1995, prohibits any practice of
12 unfair discrimination as defined by that article or an
13 act that "is determined pursuant to this article to be
14 a practice of unfair discrimination in the business of
15 insurance." V.T.I.C. Article 21.21-6 consists of five
16 sections. In addition to Section 1, only Section 4
17 contains other references to such a determination.
18 Several subsections of Section 4 refer to acts
19 "determined pursuant to Section 3" of that article to
20 be prohibited by the article. Section 3 merely
21 provides a definition of unfair discrimination and
22 does not authorize a determination that an act or
23 practice that does not satisfy the definition is
24 unfair discrimination. Consequently, the revised law
25 omits the quoted language.

26 (2) Section 4(e), V.T.I.C. Article 21.21-6, as
27 added by Chapter 415, Acts of the 74th Legislature,
28 Regular Session, 1995, refers to "community,
29 homestead, or other martial rights in land." From the
30 context, it is clear that "martial rights" is a
31 typographical error and that the reference should be
32 to "marital rights." The revised law is drafted
33 accordingly.

34 Revised Law

35 Sec. 544.003. EXCEPTIONS. (a) A person does not violate
36 Section 544.002 by providing coverage only to persons who are
37 required to obtain or maintain membership or qualification for

1 membership in a club, group, or organization to be eligible for
2 coverage if:

3 (1) the requirements are uniform requirements of the
4 insurer or health maintenance organization as a condition of
5 providing coverage and are applied uniformly throughout this state;
6 and

7 (2) the person does not engage in an act prohibited
8 under Section 544.002 against a qualified member, except as
9 provided by this section.

10 (b) A person does not violate Section 544.002(a)(2) or (3)
11 if the refusal, limitation, or charge is based on sound
12 underwriting or actuarial principles reasonably related to actual
13 or anticipated loss experience. For the purposes of this
14 subsection, a refusal, limitation, or charge relating to title
15 insurance is based on sound actuarial principles if the action is
16 based on an examination of title or on closing the transaction.

17 (c) A person does not violate Section 544.002 if the
18 refusal, limitation, or charge is required or authorized by law or a
19 regulatory mandate.

20 (d) A person does not violate Section 544.002 if
21 policyholders or enrollees with similar expense factors but
22 different loss exposures are charged different premiums or rates
23 under a mass marketing plan. The commissioner by rule shall define
24 selected groups eligible for issuance of policies or evidences of
25 coverage under a mass marketing plan. (V.T.I.C. Art. 21.21-6,
26 Secs. 4(a), (b), (c), (d), (e) (part), as added Acts 74th Leg.,
27 R.S., Ch. 415.)

28 Source Law

29 Sec. 4. (a) A legal entity engaged in the
30 business of insurance as specified in Section 2 of this
31 article is not in violation of the prohibited acts
32 defined in or determined pursuant to Sections 3(b) and
33 3(c) of this article if the refusal to insure; refusal
34 to continue to insure; the limiting of the amount,
35 extent, or kind of coverage; or the charging of an
36 individual a different rate for the same coverage is
37 based upon sound underwriting or actuarial principles
38 reasonably related to actual or anticipated loss
39 experience.

1 (b) A legal entity engaged in the business of
2 insurance as specified in Section 2 of this article is
3 not in violation of the prohibited acts defined in or
4 determined pursuant to Section 3 of this article if the
5 entity provides insurance coverage only to persons who
6 are required to obtain or maintain membership or
7 qualification for membership in a club, group, or
8 organization, so long as membership or membership
9 qualifications are uniform requirements of the insurer
10 as a condition of providing insurance, and are applied
11 uniformly throughout this state, and the entity does
12 not engage in any of the prohibited acts defined in or
13 determined pursuant to Section 3 of this article for
14 persons who are qualified members, except as otherwise
15 provided in this section.

16 (c) A legal entity engaged in the business of
17 insurance as specified in Section 2 of this article is
18 not in violation of the prohibited acts defined in or
19 determined pursuant to Section 3 of this article if the
20 refusal to insure; refusal to continue to insure; the
21 limiting of the amount, extent, or kind of coverage; or
22 the charging of an individual a different rate for the
23 same coverage is required or authorized by law or
24 regulatory mandate.

25 (d) A legal entity in the business of insurance
26 specified in Section 2 of this article is not in
27 violation of the prohibited acts defined in or
28 determined pursuant to Section 3 of this article
29 because different premiums result for policyholders
30 with like expense factors but different loss exposures
31 under a mass marketing plan. The commissioner shall by
32 rule define selected groups eligible for issuance of
33 policies under mass marketing plan.

34 (e) In this article, sound actuarial principles
35 for purposes of title insurance means based on an
36 examination of title or closing of the transaction.
37 . . .

38 Revisor's Note

39 Sections 4(a), (b), (c), and (d), V.T.I.C.
40 Article 21.21-6, as added by Chapter 415, Acts of the
41 74th Legislature, Regular Session, 1995, refer to
42 prohibited acts defined by "or determined pursuant to"
43 one or more provisions of Section 3 of that article.
44 The revised law omits references to the quoted
45 language for the reason stated in Revisor's Note (1) to
46 Section 544.002.

47 Revised Law

48 Sec. 544.004. ENFORCEMENT ACTIONS. (a) A legal entity
49 engaged in the business of insurance or a health maintenance
50 organization, that is found to be in violation of or to have failed
51 to comply with this subchapter, is subject to the sanctions
52 provided by Chapter 82, including administrative penalties

1 authorized under Chapter 84.

2 (b) In addition to the procedures provided by Subsection
3 (a), the commissioner may use the cease and desist procedures
4 authorized by Chapter 83. (V.T.I.C. Art. 21.21-6, Sec. 5, as added
5 Acts 74th Leg., R.S., Ch. 415.)

6 Source Law

7 Sec. 5. Any legal entity engaged in the business
8 of insurance in this state found to be in violation of
9 or failing to comply with this article is subject to
10 the sanctions authorized in Article 1.10 of this code,
11 including administrative penalties authorized under
12 Article 1.10E of this code. The commissioner may also
13 utilize the cease and desist procedures authorized by
14 Article 1.10A of this code.

15 [Sections 544.005-544.050 reserved for expansion]

16 SUBCHAPTER B. OTHER GENERAL PROHIBITIONS AGAINST
17 DISCRIMINATION BY INSURERS

18 Revised Law

19 Sec. 544.051. APPLICABILITY OF SUBCHAPTER. This
20 subchapter applies to any individual, corporation, association,
21 partnership, or other legal entity engaged in the business of
22 insurance, including:

- 23 (1) a fraternal benefit society;
 - 24 (2) a county mutual insurance company;
 - 25 (3) a Lloyd's plan;
 - 26 (4) a reciprocal or interinsurance exchange;
 - 27 (5) a farm mutual insurance company; and
 - 28 (6) an agent, broker, adjuster, or life and health
- 29 insurance counselor. (V.T.I.C. Art. 21.21-8, Sec. 1.)

30 Source Law

31 Art. 21.21-8
32 Sec. 1. This article shall apply to any person
33 engaged in the business of insurance. "Person" shall
34 mean any individual, corporation, association,
35 partnership, reciprocal exchange, interinsurer,
36 Lloyds insurer, fraternal benefit society, county
37 mutual, farm mutual, and any other legal entity
38 engaged in the business of insurance, including
39 agents, brokers, adjusters, and life insurance
40 counselors.

41 Revisor's Note

42 Section 1, V.T.I.C. Article 21.21-8, refers to

1 "life insurance counselors." The revised law
2 substitutes "life and health insurance counselor" for
3 the reason stated in Revisor's Note (2) to Section
4 544.001.

5 Revised Law

6 Sec. 544.052. UNFAIR DISCRIMINATION. A person may not in
7 any manner engage in unfair discrimination or permit unfair
8 discrimination between individuals of the same class and of
9 essentially the same hazard, including unfair discrimination in:

10 (1) the amount of premium, policy fees, or rates
11 charged for a policy or contract of insurance;

12 (2) the benefits payable under a policy or contract of
13 insurance; or

14 (3) any of the terms or conditions of a policy or
15 contract of insurance. (V.T.I.C. Art. 21.21-8, Sec. 2.)

16 Source Law

17 Sec. 2. No person shall engage in any unfair
18 discrimination by making or permitting any unfair
19 discrimination between individuals of the same class
20 and of essentially the same hazard in the amount of
21 premium, policy fees, or rates charged for any policy
22 or contract of insurance or in the benefits payable
23 thereunder, or in any of the terms or conditions of
24 such contract, or in any other manner whatever.

25 Revised Law

26 Sec. 544.053. EXCEPTIONS. (a) A person does not violate
27 Section 544.052 if the refusal to insure or to continue to insure,
28 the limiting of the amount, extent, or kind of coverage, or the
29 charging of an individual a rate that is different from the rate
30 charged another individual for the same coverage is based on sound
31 actuarial principles.

32 (b) A person does not violate Section 544.052 by providing
33 insurance coverage only to persons who are required to obtain or
34 maintain membership or qualification for membership in a club,
35 group, or organization to be eligible for coverage if:

36 (1) the requirements are uniform requirements of the
37 insurer as a condition of providing insurance and are applied

1 uniformly throughout this state; and

2 (2) the person does not engage in an act prohibited
3 under Section 544.052 against a qualified member, except as
4 provided by this section. (V.T.I.C. Art. 21.21-8, Secs. 4, 5.)

5 Source Law

6 Sec. 4. A legal entity engaged in the business of
7 insurance as specified in Section 1 of this article is
8 not in violation of the prohibited acts defined in or
9 determined pursuant to Section 2 of this article if the
10 refusal to insure; the refusal to continue to insure;
11 the limiting of the amount, extent, or kind of
12 coverage; or the charging of an individual a different
13 rate for the same coverage is based upon sound
14 actuarial principles.

15 Sec. 5. A legal entity engaged in the business of
16 insurance as specified in Section 1 of this article is
17 not in violation of the prohibited acts defined in or
18 determined pursuant to Section 2 of this article if the
19 entity provides insurance coverage only to persons who
20 are required to obtain or maintain membership or
21 qualification for membership in a club, group, or
22 organization so long as membership or membership
23 qualifications are uniform requirements of the insurer
24 as a condition of providing insurance, and are applied
25 uniformly throughout this state, and the entity does
26 not engage in any of the prohibited acts defined in or
27 determined pursuant to Section 2 of this article for
28 persons who are qualified members, except as otherwise
29 provided in this section.

30 Revisor's Note

31 Sections 4 and 5, V.T.I.C. Article 21.21-8, refer
32 to prohibited acts defined in or "determined pursuant
33 to Section 2 of this article." Section 2 provides a
34 description of unfair discrimination but does not
35 authorize a determination that an act or practice that
36 does not satisfy the description is unfair
37 discrimination. Consequently, the revised law omits
38 the quoted language.

39 Revised Law

40 Sec. 544.054. JUDICIAL ACTION; AWARD BY COURT. (a) A
41 person who has sustained economic damages as the result of a
42 violation of Section 544.052 may maintain only in a Travis County
43 district court an action against the person who violated that
44 section.

45 (b) An action under this section must be commenced before

1 the first anniversary of the date on which the plaintiff was denied
2 insurance or the unfair act occurred.

3 (c) A plaintiff who prevails in an action under this section
4 may obtain:

5 (1) the amount of economic damages, court costs, and
6 attorney's fees; and

7 (2) an order enjoining the violation.

8 (d) Court costs under Subsection (c) may include any
9 reasonable and necessary expert witness fees.

10 (e) If the trier of fact finds that the defendant knowingly
11 committed an act prohibited by Section 544.052, the court may award
12 a civil penalty in an amount of not more than \$25,000 for each
13 claimant.

14 (f) The court shall award the defendant reasonable and
15 necessary attorney's fees if the court finds that an action under
16 this section was:

17 (1) groundless; and

18 (2) brought in bad faith or for the purpose of
19 harassment. (V.T.I.C. Art. 21.21-8, Sec. 3.)

20 Source Law

21 Sec. 3. (a) A person who has sustained economic
22 damages as a result of another's engaging in unfair
23 discrimination, as defined in Section 2 of this
24 article, may maintain an action against the person or
25 persons engaging in such acts or practices in a
26 district court in Travis County, Texas, and not
27 elsewhere.

28 (b) In a suit filed under this article, any
29 plaintiff who prevails may obtain:

30 (1) the amount of economic damages plus
31 court costs and attorneys' fees. Court costs may
32 include any reasonable and necessary expert witness
33 fees. If the trier of fact finds that the defendant
34 knowingly committed any acts prohibited by this
35 article, the court may award a civil penalty in an
36 amount of not more than \$25,000 per claimant; and

37 (2) an order enjoining such acts or
38 failure to act.

39 (c) All actions under this article must be
40 commenced within 12 months after the date on which the
41 plaintiff was denied insurance or the unfair act
42 occurred.

43 (d) On a finding by the court that an action
44 under this section was groundless and brought in bad
45 faith or brought for the purpose of harassment, the
46 court shall award the defendant reasonable and
47 necessary attorneys' fees.

1 Revisor's Note

2 Section 3(b)(2), V.T.I.C. Article 21.21-8,
3 provides that a plaintiff in a suit against a person
4 engaging in unfair discrimination described by Section
5 2, V.T.I.C. Article 21.21-8, may obtain "an order
6 enjoining such acts or failure to act." Section
7 544.052 codifies Section 2 by prohibiting a person
8 from engaging in or permitting unfair discrimination.
9 A person violates Section 544.052 by acting, or by
10 failing to act (permitting someone else to act), in a
11 prohibited manner. Consequently, a reference to the
12 violation of Section 544.052 is sufficient, and the
13 revised law accordingly omits the reference to a
14 "failure to act."

15 [Sections 544.055-544.100 reserved for expansion]

16 SUBCHAPTER C. ENGLISH FLUENCY

17 Revised Law

18 Sec. 544.101. DEFINITIONS. In this subchapter:

19 (1) "Health benefit plan issuer" means an insurance
20 company, association, organization, group hospital service
21 corporation, or health maintenance organization that delivers or
22 issues for delivery an individual, group, blanket, or franchise
23 insurance policy or insurance agreement, a group hospital service
24 contract, or an evidence of coverage that provides health insurance
25 or health care benefits. The term includes:

26 (A) a life, health, and accident insurance
27 company operating under Chapter 841 or 982;

28 (B) a general casualty insurance company
29 operating under Chapter 861;

30 (C) a fraternal benefit society operating under
31 Chapter 885;

32 (D) a mutual life insurance company operating
33 under Chapter 882;

34 (E) a local mutual aid association operating

1 under Chapter 886;

2 (F) a statewide mutual assessment company
3 operating under Chapter 881;

4 (G) a mutual assessment company or mutual
5 assessment life, health, and accident association operating under
6 Chapter 887;

7 (H) a mutual insurance company operating under
8 Chapter 883 that writes coverage other than life insurance;

9 (I) a Lloyd's plan operating under Chapter 941;

10 (J) a reciprocal exchange operating under
11 Chapter 942; and

12 (K) a stipulated premium company operating under
13 Chapter 884.

14 (2) "Underwriting guideline" means a written,
15 electronic, or oral rule, standard, marketing decision, or practice
16 that is used by a health benefit plan issuer or an agent of a health
17 benefit plan issuer to examine, bind, accept, reject, renew or
18 refuse to renew, cancel, or limit coverages available to classes of
19 consumers or charge a different rate for the same coverage.
20 (V.T.I.C. Art. 21.21-7, Sec. 1.)

21 Source Law

22 Art. 21.21-7

23 Sec. 1. In this article:

24 (1) "Health insurer" means any insurance
25 company, group hospital service corporation, or health
26 maintenance organization that delivers or issues for
27 delivery an individual, group, blanket, or franchise
28 insurance policy or insurance agreement, a group
29 hospital service contract, or an evidence of coverage
30 that provides health insurance or health care
31 benefits. Without limiting the foregoing, the
32 definition includes insurance companies,
33 associations, and organizations which come within the
34 purview of the following designated chapters of the
35 Insurance Code: Chapter 3, pertaining to life,
36 health, and accident insurance companies; Chapter 8,
37 pertaining to general casualty companies; Chapter 10,
38 pertaining to fraternal benefit societies; Chapter
39 11, pertaining to mutual life insurance companies;
40 Chapter 12, pertaining to local mutual aid
41 associations; Chapters 13 and 14, pertaining to
42 statewide mutual assessment companies, mutual
43 assessment companies, and mutual assessment life,
44 health, and accident associations; Chapter 15,
45 pertaining to mutual insurance companies writing other
46 than life insurance; Chapter 18, pertaining to

1 underwriters making insurance on the Lloyd's plan;
2 Chapter 19, pertaining to reciprocal exchanges; and
3 Chapter 22, pertaining to stipulated premium insurance
4 companies.

5 (2) "Underwriting guideline" means a rule,
6 standard, marketing decision, or practice, whether
7 written, oral, or electronic, that is used by a health
8 insurer or an agent of a health insurer to examine,
9 bind, accept, reject, renew, nonrenew, cancel, charge
10 a different rate for the same coverage, or limit
11 coverage(s) made available to classes of consumers of
12 insurance.

13 Revisor's Note

14 (1) Section 1(1), V.T.I.C. Article 21.21-7,
15 defines "health insurer" to include health maintenance
16 organizations, which are not traditional insurers.
17 "Health benefit plan issuer" is a more accurate term
18 than "insurer," and throughout this subchapter, the
19 revised law substitutes "health benefit plan issuer"
20 for "health insurer."

21 (2) Section 1(1), V.T.I.C. Article 21.21-7,
22 provides that "[w]ithout limiting the foregoing, the
23 definition [of 'health insurer'] includes" various
24 entities. The revised law omits "[w]ithout limiting
25 the foregoing" as unnecessary because Section
26 311.005(13), Government Code (Code Construction Act),
27 and Section 312.011(19), Government Code, provide that
28 "includes" and "including" are terms of enlargement
29 and not of limitation and do not create a presumption
30 that components not expressed are excluded.

31 (3) Section 1(1), V.T.I.C. Article 21.21-7,
32 refers to Chapter 3 of the Insurance Code. The
33 relevant portions of Chapter 3, relating to life,
34 health, or accident insurance companies, are revised
35 in Chapters 841 and 982 of this code. The revised law
36 is drafted accordingly.

37 Revised Law

38 Sec. 544.102. APPLICABILITY OF SUBCHAPTER. This
39 subchapter applies to any health insurance policy, agreement,
40 contract, or evidence of coverage delivered or issued for delivery

1 by a health benefit plan issuer. (V.T.I.C. Art. 21.21-7, Sec. 2.)

2 Source Law

3 Sec. 2. This article applies to any health
4 insurance policy, agreement, contract, or evidence of
5 coverage delivered or issued for delivery by a health
6 insurer.

7 Revised Law

8 Sec. 544.103. PROHIBITION ON USE OF CERTAIN
9 GUIDELINES. (a) A health benefit plan issuer may not use an
10 underwriting guideline that is based on:

11 (1) the ability of an insured or enrollee or an
12 applicant for insurance coverage or health care benefits to speak
13 English fluently; or

14 (2) the literacy in English of the insured, enrollee,
15 or applicant.

16 (b) An applicant has the burden of proof to establish a
17 violation of this subchapter. (V.T.I.C. Art. 21.21-7, Sec. 3.)

18 Source Law

19 Sec. 3. A health insurer may not use an
20 underwriting guideline that is based on the ability of
21 an insured or an applicant for insurance coverage or
22 health care benefits to speak English fluently or to be
23 literate in the English language. The applicant has
24 the burden of proof to establish a violation of this
25 article.

26 [Sections 544.104-544.150 reserved for expansion]

27 SUBCHAPTER D. FAMILY VIOLENCE

28 Revised Law

29 Sec. 544.151. DEFINITION. In this subchapter, "family
30 violence" means an act between individuals who reside together or
31 resided together in which one individual:

32 (1) wilfully attempts to cause bodily injury, or
33 wilfully or wantonly causes bodily injury, to another;

34 (2) wilfully by physical threat places another in fear
35 of imminent bodily injury;

36 (3) engages in the act of sexual intercourse with a
37 minor under 16 years of age who is not the spouse of the individual;
38 or

1 (4) engages, with the intent to arouse or to satisfy
2 the sexual desires of the individual, a minor under 16 years of age
3 who is not the spouse of the individual, or both the individual and
4 the minor, in any lewd fondling or touching of the individual or the
5 minor. (V.T.I.C. Art. 21.21-5, Sec. 1.)

6 Source Law

7 Art. 21.21-5

8 Sec. 1. In this article, "family violence" means
9 the occurrence of one or more of the following acts
10 between persons who reside together or who formerly
11 resided together:

12 (1) wilfully attempting to cause bodily
13 injury, or wilfully or wantonly causing bodily injury;

14 (2) wilfully placing another, by physical
15 threat, in fear of imminent bodily injury; or

16 (3) engaging in any of the following acts
17 with a minor under 16 years of age who is not the spouse
18 of the person engaging in the act:

19 (A) the act of sexual intercourse; or

20 (B) any lewd fondling or touching of
21 the person of either the minor or the other person,
22 done or submitted to with the intent to arouse or to
23 satisfy the sexual desires of either the minor or the
24 other person or both.

25 Revised Law

26 Sec. 544.152. APPLICABILITY OF SUBCHAPTER. (a) This
27 subchapter applies only to:

28 (1) a life insurer that delivers, issues for delivery,
29 or renews a life insurance contract or policy in this state,
30 including a group contract, policy, or certificate of life
31 insurance; and

32 (2) a health benefit plan issuer that provides
33 benefits for medical or surgical expenses incurred as a result of a
34 health condition, accident, or sickness, including:

35 (A) an insurance company;

36 (B) a group hospital service corporation
37 operating under Chapter 842;

38 (C) a fraternal benefit society operating under
39 Chapter 885;

40 (D) a stipulated premium company operating under
41 Chapter 884;

42 (E) a health benefit plan issuer under Chapter

1 1501;

2 (F) a health maintenance organization operating
3 under Chapter 843;

4 (G) an employer under a multiple employer welfare
5 arrangement as defined by Section 3, Employee Retirement Income
6 Security Act of 1974 (29 U.S.C. Section 1002), or an analogous
7 benefit arrangement, to the extent permitted by the Employee
8 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et
9 seq.);

10 (H) an issuer of a Medicare supplemental policy
11 as defined by Section 1882(g)(1), Social Security Act (42 U.S.C.
12 Section 1395ss); and

13 (I) an approved nonprofit health corporation
14 that holds a certificate of authority issued under Chapter 844.

15 (b) This subchapter does not apply to the issuer of:

16 (1) a health benefit plan that provides coverage:

17 (A) only for a specified disease;

18 (B) only for accidental death or dismemberment;

19 (C) for wages or payments in lieu of wages for a
20 period during which an employee is absent from work because of
21 sickness or injury;

22 (D) as a supplement to liability insurance;

23 (E) only for limited benefits; or

24 (F) only for dental or vision care;

25 (2) hospital confinement indemnity coverage;

26 (3) a credit insurance policy;

27 (4) workers' compensation insurance coverage;

28 (5) medical payment insurance coverage provided under
29 a motor vehicle insurance policy; or

30 (6) a long-term care policy, including a nursing home
31 fixed indemnity policy, unless the commissioner determines that the
32 policy provides benefit coverage so comprehensive that the policy
33 is a health benefit plan as described by Subsection (a)(2).
34 (V.T.I.C. Art. 21.21-5, Sec. 2.)

1 Source Law

2 Sec. 2. (a) This article applies only to:

3 (1) a life insurer that delivers, issues
4 for delivery, or renews a life insurance contract or
5 policy in this state, including any group contract,
6 policy, or certificate of life insurance; and

7 (2) a health benefit plan issuer that
8 provides benefits for medical or surgical expenses
9 incurred as a result of a health condition, accident,
10 or sickness, including:

11 (A) an insurance company;

12 (B) a group hospital service
13 corporation operating under Chapter 20 of this code;

14 (C) a fraternal benefit society
15 operating under Chapter 10 of this code;

16 (D) a stipulated premium insurance
17 company operating under Chapter 22 of this code;

18 (E) a health carrier under Chapter 26
19 of this code;

20 (F) a health maintenance
21 organization operating under the Texas Health
22 Maintenance Organization Act (Chapter 20A, Vernon's
23 Texas Insurance Code);

24 (G) an employer under a multiple
25 employer welfare arrangement as defined by Section 3,
26 Employee Retirement Income Security Act of 1974 (29
27 U.S.C. Section 1002), or other analogous benefit
28 arrangement, to the extent permitted by the Employee
29 Retirement Income Security Act of 1974 (29 U.S.C.
30 Section 1001 et seq.);

31 (H) an issuer of a Medicare
32 supplemental policy as defined by Section 1882(g)(1),
33 Social Security Act (42 U.S.C. Section 1395ss); or

34 (I) an approved nonprofit health
35 corporation that is certified under Section 5.01(a),
36 Medical Practice Act (Article 4495b, Vernon's Texas
37 Civil Statutes), and that holds a certificate of
38 authority issued by the commissioner under Article
39 21.52F of this code.

40 (b) This article does not apply to the issuer
41 of:

42 (1) a health benefit plan that provides
43 coverage:

44 (A) only for a specified disease;

45 (B) only for accidental death or
46 dismemberment;

47 (C) for wages or payments in lieu of
48 wages for a period during which an employee is absent
49 from work because of sickness or injury;

50 (D) as a supplement to liability
51 insurance;

52 (E) only for limited benefits; or

53 (F) only for dental or vision care;

54 (2) hospital confinement indemnity
55 coverage;

56 (3) a credit insurance policy;

57 (4) workers' compensation insurance
58 coverage;

59 (5) medical payment insurance issued as
60 part of a motor vehicle insurance policy; or

61 (6) a long-term care policy, including a
62 nursing home fixed indemnity policy, unless the
63 commissioner determines that the policy provides
64 benefit coverage so comprehensive that the policy is a
65 health benefit plan as described by Subsection (a) of
66 this section.

1 Revisor's Note

2 (1) Section 2(a)(2)(E), V.T.I.C. Article
3 21.21-5, refers to a "health carrier under Chapter 26
4 of this code." The revised law substitutes "health
5 benefit plan issuer" for "health carrier" for
6 consistency with the terminology used in the revision
7 of Chapter 26. See Chapter 1501 of this code.

8 (2) Section 2(a)(2)(I), V.T.I.C. Article
9 21.21-5, refers to an approved nonprofit health
10 corporation that is "certified under Section 5.01(a),
11 Medical Practice Act," and holds a certificate of
12 authority "issued by the commissioner under Article
13 21.52F." The revised law omits the reference to
14 certification under Section 5.01(a), Medical Practice
15 Act, which was codified in 1999 as Section 162.001,
16 Occupations Code, as unnecessary because V.T.I.C.
17 Article 21.52F, revised as Chapter 844 of this code,
18 requires a nonprofit corporation to be certified under
19 Section 162.001, Occupations Code, as a condition of
20 holding a certificate of authority. The revised law
21 also omits the reference to the commissioner issuing
22 the certificate of authority as unnecessary because
23 Chapter 844 requires the commissioner to issue the
24 certificate of authority.

25 Revised Law

26 Sec. 544.153. PROHIBITIONS. (a) A health benefit plan
27 issuer or life insurer may not, because of an individual's status as
28 a victim of family violence:

- 29 (1) deny coverage to the individual;
30 (2) refuse to renew the individual's coverage;
31 (3) cancel the individual's coverage;
32 (4) limit the amount, extent, or kind of coverage
33 available to the individual; or
34 (5) charge the individual or a group to which the

1 individual belongs a rate that is different from the rate charged to
2 other individuals or groups, respectively, for the same coverage.

3 (b) A health benefit plan issuer or life insurer may not, as
4 a part of an application for coverage, require an applicant to
5 reveal whether the applicant has been or may become a victim of
6 family violence. (V.T.I.C. Art. 21.21-5, Sec. 3.)

7 Source Law

8 Sec. 3. (a) A health benefit plan issuer or
9 life insurer, because of an individual's status as a
10 victim of family violence, may not:

- 11 (1) deny coverage to the individual;
12 (2) refuse to renew the individual's
13 coverage;
14 (3) cancel the individual's coverage;
15 (4) limit the amount, extent, or kind of
16 coverage available to the individual; or
17 (5) charge the individual or a group to
18 which the individual belongs a different rate for the
19 same coverage.

20 (b) A health benefit plan issuer or life insurer
21 may not, as a part of an application for coverage,
22 require an applicant to reveal whether the applicant
23 has been or may become a victim of family violence.

24 Revised Law

25 Sec. 544.154. CONFIDENTIALITY OF CERTAIN INFORMATION. (a)
26 Except as provided by Subsection (b), a health benefit plan issuer,
27 life insurer, or person employed by or under contract with a health
28 benefit plan issuer or life insurer may not release information
29 relating to the status as a victim of family violence of an
30 individual who is clearly a victim of family violence, including:

- 31 (1) information about specific acts of family violence
32 directed at the individual;
33 (2) the individual's address or telephone number at
34 home or at work; and
35 (3) information about the individual's employment,
36 associations, family membership, or relationships.

37 (b) A health benefit plan issuer or life insurer may release
38 information to which Subsection (a) applies only:

- 39 (1) to the individual;
40 (2) to another individual designated in writing by the
41 individual;

1 (3) to a licensed physician designated by the
2 individual;

3 (4) to a physician or other health care provider for
4 the provision of health care services;

5 (5) to an attorney who needs the information to
6 effectively represent the issuer or insurer, if the issuer or
7 insurer notifies the attorney of the requirements of this
8 subchapter and requests that the attorney exercise due diligence to
9 protect the information consistent with the attorney's obligation
10 to represent the issuer or insurer;

11 (6) to an individual covered under, or the owner of,
12 the health benefit plan or life insurance contract or policy that
13 contains information about status as a victim of family violence;

14 (7) to an individual or entity to whom the
15 commissioner considers the release appropriate;

16 (8) as required by other law or an order of the
17 commissioner or a court; or

18 (9) as necessary for a valid business purpose if:

19 (A) the information cannot be segregated from
20 other information about the individual without undue hardship to
21 the issuer or insurer;

22 (B) the recipient of the information is:

23 (i) a reinsurer that seeks to indemnify or
24 indemnifies all or part of a health benefit plan or life insurance
25 contract or policy covering the individual if the reinsurer cannot
26 underwrite or satisfy obligations under the reinsurance agreement
27 without the release of the information;

28 (ii) a party to a proposed or consummated
29 sale, transfer, merger, or consolidation of all or part of the
30 business of the issuer or insurer;

31 (iii) medical or claims personnel under
32 contract with the issuer or insurer, including a parent or
33 affiliate company under a service agreement with the issuer or
34 insurer, if the release of the information is necessary to process

1 an application, to perform duties under the health benefit plan or
2 life insurance contract or policy, or to protect the safety or
3 privacy of a victim of family violence; or

4 (iv) an entity with which the issuer
5 transacts business if the information is only the address or
6 telephone number of the individual and the entity cannot transact
7 the business without the address or telephone number; and

8 (C) the recipient of the information agrees in
9 writing to be subject to the requirements of this subchapter.

10 (V.T.I.C. Art. 21.21-5, Sec. 8.)

11 Source Law

12 Sec. 8. (a) Except as provided by Subsection
13 (b) of this section, a health benefit plan issuer, life
14 insurer, or person employed by or under contract with a
15 health benefit plan issuer or life insurer may not
16 release information relating to the status as a victim
17 of family violence of an individual who is clearly a
18 victim of family violence, including:

19 (1) information about specific acts of
20 family violence directed at the individual;

21 (2) the individual's address or phone
22 number at home or at work; and

23 (3) information about the individual's
24 employment, associations, family membership, or
25 relationships.

26 (b) A health benefit plan issuer or life insurer
27 may only release information relating to the status as
28 a victim of family violence of an individual who is
29 clearly a victim of family violence:

30 (1) to the victim or another individual
31 designated in writing by the victim;

32 (2) to a physician or health care provider
33 for the provision of health care services;

34 (3) to a licensed physician designated by
35 the victim;

36 (4) as required by other law or an order of
37 the commissioner or a court of competent jurisdiction;

38 (5) when necessary for a valid business
39 purpose if:

40 (A) the information cannot be
41 segregated from other information about the victim
42 without undue hardship to the health benefit plan
43 issuer or life insurer;

44 (B) the recipient of the information
45 agrees in writing to be subject to the requirements of
46 this article; and

47 (C) the recipient of the information
48 is:

49 (i) a reinsurer that seeks to
50 indemnify or indemnifies all or any part of a health
51 benefit plan or life insurance contract or policy
52 covering the victim of family violence when the
53 reinsurer cannot underwrite or satisfy obligations
54 under the reinsurance agreement without release of the
55 information;

56 (ii) a party to a proposed or

1 consummated sale, transfer, merger, or consolidation
2 of all or part of the business of the health benefit
3 plan provider or life insurer;

4 (iii) medical or claims
5 personnel under contract with the health benefit plan
6 provider or life insurer, including parent or
7 affiliate companies under service agreements with the
8 health benefit plan provider or life insurer, when
9 release of the information is necessary to process an
10 application, to perform duties under the health
11 benefit plan or life insurance contract or policy, or
12 to protect the safety or privacy of a victim of family
13 violence; or

14 (iv) an entity with which the
15 health benefit plan provider transacts business when
16 the information is only the address or telephone
17 number of the victim and the entity cannot transact the
18 business without the address or telephone number;

19 (6) to an attorney who needs the
20 information to represent effectively the health
21 benefit plan issuer or the life insurer, if the health
22 benefit plan issuer or life insurer notifies the
23 attorney of requirements of this article and requests
24 that the attorney exercise due diligence to protect
25 the information consistent with the attorney's
26 obligation to represent the health benefit plan issuer
27 or life insurer;

28 (7) to the individual covered under or
29 owner of the health benefit plan or life insurance
30 contract or policy, if the plan, contract, or policy
31 contains information about status as a victim of
32 family violence; or

33 (8) to any other individual or entity
34 deemed appropriate by the commissioner.

35 Revisor's Note

36 Section 8(b)(4), V.T.I.C. Article 21.21-5,
37 refers to an order of "a court of competent
38 jurisdiction." The revised law omits "of competent
39 jurisdiction" as unnecessary because an order of a
40 court that does not have jurisdiction over a matter is
41 not a valid order, and the general laws of civil
42 jurisdiction determine which courts have jurisdiction
43 over the matter. For example, see Sections
44 24.007-24.011, Government Code, for the general
45 jurisdiction of district courts.

46 Revised Law

47 Sec. 544.155. UNDERWRITING CRITERIA. Notwithstanding any
48 other provision of this subchapter, a health benefit plan issuer or
49 life insurer may underwrite a risk on the basis of an individual's
50 physical or mental condition regardless of the underlying cause of
51 the condition or on the basis of any underwriting criteria not

1 prohibited by this code or another insurance law of this state or a
2 rule adopted under this code or another insurance law of this state
3 if the issuer or insurer consistently applies the criteria and does
4 not merely use the criteria as a pretext to evade the application of
5 Section 544.153. (V.T.I.C. Art. 21.21-5, Sec. 6.)

6 Source Law

7 Sec. 6. Notwithstanding any other provision of
8 this article, a health benefit plan issuer or life
9 insurer may underwrite a risk on the basis of an
10 individual's physical or mental condition regardless
11 of the underlying cause of the condition, or on the
12 basis of any underwriting criteria not prohibited by
13 this code, another insurance law of this state, or a
14 rule adopted under this code or another insurance law
15 of this state, provided that the health benefit plan
16 issuer or life insurer consistently applies the
17 criteria and does not merely use the criteria as a
18 pretext to evade application of Section 3 of this
19 article.

20 Revised Law

21 Sec. 544.156. HEALTH BENEFIT PLAN ISSUER OR LIFE INSURER
22 NOT LIABLE FOR DEATH OR BODILY INJURY. A health benefit plan
23 issuer or life insurer that delivers, issues for delivery, or
24 renews a health benefit plan or a life insurance policy or contract
25 for an individual who has been or may become a victim of family
26 violence may not be held civilly or criminally liable for the death
27 of or bodily injuries incurred by that individual as a result of
28 family violence. (V.T.I.C. Art. 21.21-5, Sec. 5.)

29 Source Law

30 Sec. 5. A health benefit plan provider or life
31 insurer who delivers, issues for delivery, or renews a
32 health benefit plan or a life insurance policy or
33 contract for an individual who has been or may become a
34 victim of family violence may not be held civilly or
35 criminally liable for the death of, or bodily injuries
36 incurred by, that individual as a result of family
37 violence.

38 Revised Law

39 Sec. 544.157. RIGHT TO CONTINUED COVERAGE
40 UNAFFECTED. This subchapter does not affect the right of an
41 individual to continued coverage under Subchapter G, Chapter 1251.
42 (V.T.I.C. Art. 21.21-5, Sec. 7.)

1 Source Law

2 Sec. 7. This article does not affect the right of
3 an individual to continued coverage under Section 3B,
4 Article 3.51-6, Insurance Code.

5 Revised Law

6 Sec. 544.158. UNFAIR OR DECEPTIVE ACT OR PRACTICE. A
7 violation of this subchapter is an unfair or deceptive act or
8 practice under Chapter 541. (V.T.I.C. Art. 21.21-5, Sec. 4.)

9 Source Law

10 Sec. 4. A health benefit plan issuer or life
11 insurer who violates this article commits an unfair
12 and deceptive practice as defined by Article 21.21 of
13 this code and is subject to the penalties imposed under
14 that article.

15 Revisor's Note

16 Section 4, V.T.I.C. Article 21.21-5, provides
17 that a violation of the article is an "unfair and
18 deceptive practice" under V.T.I.C. Article 21.21. The
19 revised law adds the term "act" so that the phrase
20 reads, "an unfair or deceptive act or practice" to
21 conform to the terminology used in Article 21.21.
22 Section 4, V.T.I.C. Article 21.21-5, also provides
23 that a violation of the article is "subject to the
24 penalties imposed under that article" (meaning Article
25 21.21). Since a violation of Article 21.21 by its terms
26 subjects the violator to the penalties provided under
27 that article, the revised law omits the quoted
28 language as unnecessary.

29 [Sections 544.159-544.200 reserved for expansion]

30 SUBCHAPTER E. FIBROCYSTIC BREAST CONDITION

31 Revised Law

32 Sec. 544.201. DEFINITION. In this subchapter, "health
33 benefit plan issuer" means an insurer, a group hospital service
34 corporation operating under Chapter 842, or a health maintenance
35 organization operating under Chapter 843 that delivers or issues
36 for delivery or renews any health insurance policy or contract in
37 this state, including a group policy, contract, or certificate of

1 health insurance or evidence of coverage. (V.T.I.C. Art. 21.21-6,
2 Sec. (a), as added Acts 74th Leg., R.S., Ch. 522.)

3 Source Law

4 Art. 21.21-6. (a) In this article, "insurer"
5 means an insurer who delivers or issues for delivery or
6 renews any health insurance policy or contract in this
7 state, including any group policy, contract, or
8 certificate of health insurance or evidence of
9 coverage delivered, issued for delivery, or renewed in
10 this state. The term includes a group hospital service
11 corporation under Chapter 20 of this code and a health
12 maintenance organization under the Texas Health
13 Maintenance Organization Act (Chapter 20A, Vernon's
14 Texas Insurance Code).

15 Revisor's Note

16 Section (a), V.T.I.C. Article 21.21-6, as added
17 by Chapter 522, Acts of the 74th Legislature, Regular
18 Session, 1995, defines "insurer" to include health
19 maintenance organizations. Throughout this
20 subchapter, the revised law substitutes "health
21 benefit plan issuer" for "insurer" for the reason
22 stated in Revisor's Note (1) to Section 544.101.

23 Revised Law

24 Sec. 544.202. PROHIBITION. A health benefit plan issuer
25 may not, solely or in part because an individual has been diagnosed
26 with or has a history of a fibrocystic breast condition:

- 27 (1) deny coverage to the individual;
28 (2) refuse to renew the individual's coverage;
29 (3) cancel the individual's coverage;
30 (4) limit the amount, extent, or kind of coverage
31 available to the individual for any other breast condition; or
32 (5) charge the individual or a group to which the

33 individual belongs a rate that is different from the rate charged to
34 other individuals or groups, respectively, for the same coverage.
35 (V.T.I.C. Art. 21.21-6, Sec. (b), as added Acts 74th Leg., R.S., Ch.
36 522.)

37 Source Law

38 (b) An insurer, solely or in part because an
39 individual has been diagnosed with or has a history of
40 a fibrocystic breast condition, may not:

- 1 (1) deny coverage to the individual;
2 (2) refuse to renew a policy of insurance
3 covering the individual;
4 (3) cancel a policy of insurance covering
5 the individual;
6 (4) limit the amount, extent, or kind of
7 coverage available to the individual for any other
8 breast condition; or
9 (5) charge the individual or a group to
10 which the individual belongs a different rate for the
11 same coverage.

12 Revisor's Note

13 Sections (b)(2) and (3), V.T.I.C. Article
14 21.21-6, as added by Chapter 522, Acts of the 74th
15 Legislature, Regular Session, 1995, provide that under
16 certain circumstances an insurer may not cancel or
17 refuse to renew "a policy of insurance covering the
18 individual." Section (a), Article 21.21-6, revised as
19 Section 544.201, defines "insurer" as an insurer,
20 group hospital service corporation, or health
21 maintenance organization that issues or delivers "any
22 health insurance policy or contract in this state,
23 including any group policy, contract, or certificate
24 of health insurance or evidence of coverage." It is
25 clear that Sections (b)(2) and (3), Article 21.21-6,
26 apply to a health insurance contract, certificate of
27 health insurance, or evidence of coverage as well as to
28 "a policy of insurance." Accordingly, the revised law
29 substitutes "the individual's coverage" for "a policy
30 of insurance covering the individual."

31 Revised Law

32 Sec. 544.203. UNFAIR OR DECEPTIVE ACT OR PRACTICE. A
33 violation of this subchapter is an unfair or deceptive act or
34 practice under Chapter 541. (V.T.I.C. Art. 21.21-6, Sec. (c), as
35 added Acts 74th Leg., R.S., Ch. 522.)

36 Source Law

37 (c) An insurer who violates this article commits
38 an unfair and deceptive practice as defined by Article
39 21.21 of this code and is subject to the penalties
40 imposed under that article.

1 Revisor's Note

2 Section (c), V.T.I.C. Article 21.21-6, as added
3 by Chapter 522, Acts of the 74th Legislature, Regular
4 Session, 1995, provides that a violation of the
5 article is an "unfair and deceptive practice" under
6 Article 21.21 and "is subject to the penalties imposed
7 under that article." The revised law adds the term
8 "act" and omits the reference to penalties for the
9 reasons stated in the revisor's note to Section
10 544.158.

11 Revised Law

12 Sec. 544.204. PAYMENT FOR DISEASE NOT REQUIRED. This
13 subchapter does not require a health benefit plan issuer to pay
14 benefits for fibrocystic breast disease. (V.T.I.C. Art. 21.21-6,
15 Sec. (d), as added Acts 74th Leg., R.S., Ch. 522.)

16 Source Law

17 (d) Nothing in this article requires insurers to
18 pay for fibrocystic breast disease.

19 [Sections 544.205-544.250 reserved for expansion]

20 SUBCHAPTER F. CHURCH PROPERTY

21 Revised Law

22 Sec. 544.251. DEFINITIONS. In this subchapter:

23 (1) "Church" means a facility that is owned by a
24 religious organization and is used primarily for religious
25 services.

26 (2) "Religious organization" means a church,
27 synagogue, or other organization or association organized
28 primarily for religious purposes. (V.T.I.C. Art. 21.21-9, Sec. 1,
29 as added Acts 75th Leg., R.S., Ch. 1007.)

30 Source Law

31 Art. 21.21-9

32 Sec. 1. In this article:

33 (1) "Church" means a facility that is
34 owned by a religious organization and that is used
35 primarily for religious services.

36 (2) "Religious organization" means a
37 church, synagogue, or other organization or
38 association that is organized primarily for religious

1 purposes.

2 Revised Law

3 Sec. 544.252. APPLICABILITY OF SUBCHAPTER. This
4 subchapter applies to an insurer that is admitted to engage in the
5 business of insurance and authorized to write an insurance policy
6 providing coverage for losses resulting from fire in this state,
7 including a county mutual insurance company, a Lloyd's plan, a
8 reciprocal or interinsurance exchange, or a farm mutual insurance
9 company. (V.T.I.C. Art. 21.21-9, Sec. 2, as added Acts 75th Leg.,
10 R.S., Ch. 1007.)

11 Source Law

12 Sec. 2. This article applies to any insurer
13 admitted to do business and authorized to write an
14 insurance policy providing coverage for losses
15 resulting from fire in this state, including a county
16 mutual insurance company, a Lloyd's plan company, a
17 reciprocal or interinsurance exchange, or a farm
18 mutual insurance company.

19 Revised Law

20 Sec. 544.253. PROHIBITION. An insurer writing insurance
21 for a church may not cancel or decline to renew an insurance policy
22 solely because of:

23 (1) an occurrence of arson against the church, if the
24 religious organization that owns the church cooperated with police,
25 fire, and other authorities in the investigation of the arson and in
26 the prosecution of those responsible for the arson; or

27 (2) a verbal or written threat of arson against the
28 church that was directed to the religious organization or an
29 official of the religious organization and that the organization or
30 official reported to the appropriate law enforcement agency within
31 a reasonable amount of time. (V.T.I.C. Art. 21.21-9, Sec. 3, as
32 added Acts 75th Leg., R.S., Ch. 1007.)

33 Source Law

34 Sec. 3. An insurer writing insurance for a
35 church may not cancel or decline to renew an insurance
36 policy solely because of:

37 (1) a previous occurrence of arson against
38 the church in which the church has cooperated with
39 police, fire, and other authorities in the
40 investigation of the arson and the prosecution of
41 those responsible; or

1 (2) a verbal or written statement directed
2 to the religious organization or an official of the
3 religious organization threatening an act of arson
4 against the church when the organization or official
5 within a reasonable amount of time reported the threat
6 to the appropriate law enforcement agency.

7 Revised Law

8 Sec. 544.254. UNFAIR OR DECEPTIVE ACT OR PRACTICE. A
9 violation of this subchapter is an unfair or deceptive act or
10 practice in the business of insurance under Chapter 541. (V.T.I.C.
11 Art. 21.21-9, Sec. 4, as added Acts 75th Leg., R.S., Ch. 1007.)

12 Source Law

13 Sec. 4. A violation of this article is an unfair
14 act or practice in the business of insurance for
15 purposes of Article 21.21 and an insurer that violates
16 this article is subject to the sanctions established
17 by Article 21.21.

18 Revisor's Note

19 Section 4, V.T.I.C. Article 21.21-9, as added by
20 Chapter 1007, Acts of the 75th Legislature, Regular
21 Session, 1997, provides that a violation of the
22 article is an "unfair act or practice" under Article
23 21.21 and that "an insurer that violates this article
24 is subject to the sanctions established by Article
25 21.21." The revised law adds the term "deceptive" so
26 that the phrase reads, "an unfair or deceptive act or
27 practice" to conform to the terminology used in
28 Article 21.21. The revised law omits the reference to
29 sanctions for the reason stated in the revisor's note
30 to Section 544.158.

31 CHAPTER 545. HIV TESTING

32 SUBCHAPTER A. GENERAL PROVISIONS

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36 [Sections 545.004-545.050 reserved for expansion]

37 SUBCHAPTER B. ISSUER POWERS AND DUTIES

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4 Sec. 545.056. ADVERSE UNDERWRITING DECISION; TEST PROTOCOL

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6 Sec. 545.057. CONFIDENTIALITY OF TEST RESULT REQUIRED 342

7 [Sections 545.058-545.700 reserved for expansion]

8 SUBCHAPTER O. SANCTIONS; PENALTIES; INJUNCTIONS

9 Sec. 545.701. SANCTIONS 343

10 Sec. 545.702. CIVIL ACTION; PENALTY 343

11 Sec. 545.703. CRIMINAL PENALTY 345

12 CHAPTER 545. HIV TESTING

13 SUBCHAPTER A. GENERAL PROVISIONS

14 Revised Law

15 Sec. 545.001. DEFINITIONS. In this chapter:

16 (1) "AIDS" has the meaning assigned by Section 81.101,

17 Health and Safety Code.

18 (2) "Applicant" means an individual who applies to an

19 issuer for coverage.

20 (3) "HIV" has the meaning assigned by Section 81.101,

21 Health and Safety Code.

22 (4) "Issuer" means a person who delivers, issues for

23 delivery, or renews coverage in this state, including a group

24 policy, contract, or certificate of health insurance or evidence of

25 coverage delivered, issued for delivery, or renewed in this state

26 by an insurer, including a group hospital service corporation

27 operating under Chapter 842, or by a health maintenance

28 organization operating under Chapter 843.

29 (5) "Test result" means a statement:

30 (A) that an identifiable individual is positive,

31 negative, at risk, or has or does not have a certain level of

32 antigen or antibody; or

33 (B) that indicates that an identifiable

34 individual has or has not been tested for AIDS or HIV infection,

1 antibodies to HIV, or infection with any other probable causative
2 agent of AIDS. (V.T.I.C. Art. 21.21-4, Sec. (a); New.)

3 Source Law

4 Art. 21.21-4. (a) In this article:

5 (1) "HIV" and "AIDS" have the meanings
6 assigned by Section 81.101, Health and Safety Code.

7 (2) "Insurer" means an insurer who
8 delivers or issues for delivery or renews any
9 insurance in this state including any group policy,
10 contract, or certificate of health insurance or
11 evidence of coverage delivered, issued for delivery,
12 or renewed in this state by an insurance company,
13 including a group hospital service corporation under
14 Chapter 20 of this code and a health maintenance
15 organization under the Texas Health Maintenance
16 Organization Act (Chapter 20A, Vernon's Texas
17 Insurance Code).

18 (3) "Test result" means any statement or
19 assertion that any identifiable individual is
20 positive, negative, at risk, has or does not have a
21 certain level of antigen or antibody, or any other
22 statement that indicates that an identifiable
23 individual has or has not been tested for AIDS or HIV
24 infection, antibodies to HIV, or infection with any
25 other probable causative agent of AIDS.

26 Revisor's Note

27 (1) A definition of "applicant" is added to the
28 revised law for drafting convenience and to avoid
29 unnecessary repetition of the substance of the
30 definition.

31 (2) Section (a)(2), V.T.I.C. Article 21.21-4,
32 provides a definition of "insurer." The revised law
33 substitutes "issuer" for "insurer" because the
34 definition of "insurer" includes persons, such as
35 health maintenance organizations, that issue health
36 coverage but are not insurers. Consequently, "issuer"
37 is a more accurate term.

38 (3) Section (a)(3), V.T.I.C. Article 21.21-4,
39 refers to "any statement or assertion." The revised
40 law omits "assertion" because, in context, "assertion"
41 is included within the meaning of "statement."

42 Revised Law

43 Sec. 545.002. EXCLUSIVE APPLICABILITY. This chapter and
44 rules adopted under this chapter exclusively govern the practices

1 of an issuer in testing applicants to determine or help determine if
2 an applicant has:

- 3 (1) AIDS or HIV infection;
- 4 (2) antibodies to HIV; or
- 5 (3) an infection with any other probable causative
6 agent of AIDS. (V.T.I.C. Art. 21.21-4, Sec. (p).)

7 Source Law

8 (p) The provisions of this article and any rules
9 and regulations adopted pursuant to this article shall
10 exclusively govern all practices of insurers in
11 testing applicants to show or help show whether a
12 person has AIDS or HIV infection, antibodies to HIV, or
13 infection with any other probable causative agent of
14 AIDS.

15 Revisor's Note

16 Section (p), V.T.I.C. Article 21.21-4, refers to
17 "rules and regulations." The revised law omits the
18 reference to "regulations" because under Section
19 311.005(5), Government Code (Code Construction Act), a
20 rule is defined to include a regulation. That
21 definition applies to the revised law.

22 Revised Law

23 Sec. 545.003. RULES. The commissioner may adopt:

- 24 (1) reasonable rules and forms necessary to implement
25 this chapter; and
- 26 (2) rules to be followed for an HIV-related test
27 requested or required by an issuer. (V.T.I.C. Art. 21.21-4, Sec.
28 (i).)

29 Source Law

30 (i) The State Board of Insurance may adopt
31 reasonable rules and forms necessary to implement this
32 article and also may adopt rules relating to
33 HIV-related tests to be followed for tests requested
34 or required by insurers.

35 Revisor's Note

36 Section (i), V.T.I.C. Article 21.21-4, refers to
37 the State Board of Insurance. Chapter 685, Acts of the
38 73rd Legislature, Regular Session, 1993, abolished the
39 board and transferred its functions to the

1 commissioner of insurance and the Texas Department of
2 Insurance. Throughout this chapter, references to the
3 board have been changed appropriately.

4 [Sections 545.004-545.050 reserved for expansion]

5 SUBCHAPTER B. ISSUER POWERS AND DUTIES

6 Revised Law

7 Sec. 545.051. HIV-RELATED TESTING AUTHORIZED. An issuer
8 may request or require an applicant to take an HIV-related test in
9 connection with the application. (V.T.I.C. Art. 21.21-4, Sec. (b)
10 (part).)

11 Source Law

12 (b) An insurer may request or require applicants
13 for insurance coverage to take an HIV-related test in
14 connection with an application for insurance
15 coverage. . . .

16 Revised Law

17 Sec. 545.052. NONDISCRIMINATORY BASIS REQUIRED. (a) An
18 issuer that requests or requires applicants to take an HIV-related
19 test must request or require the test on a nondiscriminatory basis.

20 (b) An issuer may require an applicant to take an
21 HIV-related test only if:

22 (1) the test is based on the applicant's current
23 medical condition or medical history; or

24 (2) underwriting guidelines for the coverage amounts
25 require all applicants in the risk class to be tested.

26 (c) In determining who will be requested or required to take
27 an HIV-related test, an issuer may not use the marital status,
28 occupation, sex, beneficiary designation, or territorial
29 classification, including zip code, of an applicant. (V.T.I.C.
30 Art. 21.21-4, Secs. (b) (part), (h).)

31 Source Law

32 (b) . . . If an insurer requests or requires
33 applicants for insurance coverage to take an
34 HIV-related test, the insurer must request or require
35 the tests on a nondiscriminatory basis. An
36 HIV-related test may be required of or required to be
37 given to a person only if the test is based on the
38 person's current medical condition or medical history
39 or if underwriting guidelines for the coverage amounts

1 require all persons within the risk class to be tested.

2 (h) The marital status, occupation, gender,
3 beneficiary designation, or zip code or other
4 territorial classification of a proposed insured may
5 not be used by an insurer in making a determination as
6 to who will be required or requested to take an
7 HIV-related test.

8 Revised Law

9 Sec. 545.053. EXPLANATION AND AUTHORIZATION REQUIRED. (a)

10 An issuer that requests or requires an applicant to take an
11 HIV-related test in connection with an application must:

12 (1) provide an explanation to the applicant, or
13 another person legally authorized to consent to the test, of how the
14 test will be used; and

15 (2) obtain a written authorization from the person to
16 whom the explanation is provided.

17 (b) The authorization must:

18 (1) be on a form adopted by the commissioner; and

19 (2) be separate from any other document presented to
20 the applicant or other person legally authorized to consent to the
21 test. (V.T.I.C. Art. 21.21-4, Sec. (c).)

22 Source Law

23 (c) If a proposed insured is requested or
24 required to take an HIV-related test in connection
25 with an insurance application, the uses that will be
26 made of the test must be explained to the proposed
27 insured or any other person legally authorized to
28 consent to the test and a written authorization must be
29 obtained from that person by the insurer. The
30 authorization must be on a form adopted by the State
31 Board of Insurance and must be a document separate from
32 any other document presented to the proposed insured
33 or other person legally authorized to consent to the
34 test.

35 Revised Law

36 Sec. 545.054. INQUIRIES REGARDING PREVIOUS TESTS. (a) An
37 issuer may inquire whether an applicant has:

38 (1) tested positive on an HIV-related test; or

39 (2) been diagnosed with HIV or AIDS.

40 (b) An issuer may not inquire whether an applicant has been
41 tested for or has received a negative result from a specific test
42 for:

- 1 (1) exposure to HIV; or
2 (2) a sickness or a medical condition derived from
3 infection with HIV. (V.T.I.C. Art. 21.21-4, Sec. (d).)

4 Source Law

5 (d) An insurer may inquire if an applicant has
6 ever tested positive on an HIV-related test or has been
7 diagnosed as having HIV or AIDS. An insurer may not
8 inquire whether a person has been tested for or has
9 received a negative result from a specific test for
10 exposure to HIV or for a sickness or a medical
11 condition derived from infection with that virus.

12 Revised Law

13 Sec. 545.055. NOTICE OF POSITIVE TEST RESULT; FEE. (a) An
14 applicant must be given written notice of a positive HIV-related
15 test result by:

- 16 (1) a physician designated by the applicant; or
17 (2) the Texas Department of Health, if the applicant
18 has not designated a physician.

19 (b) The Texas Department of Health by rule may set a fee, not
20 to exceed \$25, to cover the cost of giving written notice under this
21 section. (V.T.I.C. Art. 21.21-4, Sec. (f).)

22 Source Law

23 (f) An applicant must be given written notice of
24 a positive HIV-related test result by a physician
25 designated by the applicant or, in the absence of that
26 designation, by the Texas Department of Health. The
27 Texas Department of Health is authorized to set by rule
28 a fee to cover the costs of providing this service to
29 the insurer. The fee may not exceed \$25.

30 Revised Law

31 Sec. 545.056. ADVERSE UNDERWRITING DECISION; TEST PROTOCOL
32 RULES. An issuer may not make an adverse underwriting decision
33 based on a positive HIV-related test unless a test protocol
34 established by commissioner rule is followed. (V.T.I.C. Art.
35 21.21-4, Sec. (g).)

36 Source Law

37 (g) An insurer may not make an adverse
38 underwriting decision based on a positive HIV-related
39 test unless test protocol as established by rule of the
40 State Board of Insurance is followed in testing.

1 Revised Law

2 Sec. 545.057. CONFIDENTIALITY OF TEST RESULT
3 REQUIRED. (a) An HIV-related test result is confidential.

4 (b) An issuer may not release or disclose the test result or
5 otherwise allow the test result to become known except as:

6 (1) required by law; or

7 (2) requested or authorized in writing by the
8 applicant or a person legally authorized to consent to the test on
9 the applicant's behalf.

10 (c) A test result released under Subsection (b)(2) may be
11 released only to:

12 (1) the applicant;

13 (2) a person legally authorized to consent to the
14 test;

15 (3) a licensed physician, medical practitioner, or
16 other person designated by the applicant;

17 (4) an insurance medical information exchange under
18 procedures designed to ensure confidentiality, including the use of
19 general codes that cover results of tests for other diseases or
20 conditions not related to AIDS, or for the preparation of
21 statistical reports that do not disclose the identity of any
22 particular applicant;

23 (5) a reinsurer, if the reinsurer is involved in the
24 underwriting process, under procedures designed to ensure
25 confidentiality;

26 (6) persons within the issuer's organization who have
27 the responsibility to make underwriting decisions for the issuer;
28 or

29 (7) outside legal counsel that needs the information
30 to effectively represent the issuer regarding the applicant.

31 (V.T.I.C. Art. 21.21-4, Sec. (e).)

32 Source Law

33 (e) The result of an HIV-related test is
34 confidential, and an insurer may not release or
35 disclose the test result or allow the test result to

1 become known except in the following circumstances:

2 (1) as may be required by law; or

3 (2) pursuant to the written request or
4 authorization of the proposed insured or other person
5 legally authorized to consent to the test on behalf of
6 the proposed insured, with the release pursuant to
7 written request limited to:

8 (A) the proposed insured;

9 (B) the person legally authorized to
10 consent to the test;

11 (C) a licensed physician, medical
12 practitioner, or other person designated by the
13 proposed insured;

14 (D) an insurance medical information
15 exchange under procedures that are designed to assure
16 confidentiality, including the use of general codes
17 that also cover results of tests for other diseases or
18 conditions not related to AIDS, or for the preparation
19 of statistical reports that do not disclose the
20 identity of any particular proposed insured;

21 (E) a reinsurer, if the reinsurer is
22 involved in the underwriting process, under procedures
23 that are designed to assure confidentiality;

24 (F) persons within the insurer's
25 organization who have the responsibility to make
26 underwriting decisions on behalf of the insurer; or

27 (G) outside legal counsel who needs
28 the information to effectively represent the insurer
29 in regard to matters concerning the proposed insured.

30 [Sections 545.058-545.700 reserved for expansion]

31 SUBCHAPTER O. SANCTIONS; PENALTIES; INJUNCTIONS

32 Revised Law

33 Sec. 545.701. SANCTIONS. The commissioner may impose
34 sanctions under Chapter 82 on an issuer that violates this chapter.

35 (V.T.I.C. Art. 21.21-4, Sec. (q).)

36 Source Law

37 (q) An insurer that violates this article is
38 subject to the sanctions provided by Section (7) of
39 Article 1.10 of this code.

40 Revised Law

41 Sec. 545.702. CIVIL ACTION; PENALTY. (a) A person who is
42 injured by a violation of Section 545.057 may bring a civil action
43 for damages.

44 (b) A person may bring an action to restrain a violation or
45 threatened violation of Section 545.057.

46 (c) If it is found in a civil action that a person or entity
47 has released or disclosed a test result or allowed a test result to
48 become known in violation of Section 545.057, the person or entity
49 is liable for:

- 1 (1) actual damages;
- 2 (2) a civil penalty of:
- 3 (A) not more than \$1,000 if the release or
- 4 disclosure was negligent; or
- 5 (B) not less than \$1,000 or more than \$5,000 if
- 6 the release or disclosure was wilful; and
- 7 (3) court costs and reasonable attorney's fees
- 8 incurred by the person bringing the action.
- 9 (d) A defendant in a civil action brought under this section
- 10 is not entitled to claim a privilege as a defense to the action.
- 11 (V.T.I.C. Art. 21.21-4, Secs. (j), (k), (l), (o).)

12 Source Law

13 (j) Any person who is injured by a violation of

14 Subsection (e) of this article may bring a civil action

15 for damages. In addition, any person may bring an

16 action to restrain a violation or threatened violation

17 of Subsection (e) of this article.

18 (k) If it is found in a civil action that a

19 person or entity has negligently released or disclosed

20 a test result or allowed a test result to become known

21 in violation of Subsection (e) of this article, the

22 person or entity is liable for:

- 23 (1) actual damages;
- 24 (2) a civil penalty of not more than
- 25 \$1,000; and

26 (3) court costs and reasonable attorney's

27 fees incurred by the person bringing the action.

28 (l) If it is found in a civil action that a

29 person or entity has wilfully released or disclosed a

30 test result or allowed a test result to become known in

31 violation of Subsection (e) of this article, the

32 person or entity is liable for:

- 33 (1) actual damages;
- 34 (2) a civil penalty of not less than \$1,000
- 35 nor more than \$5,000; and

36 (3) court costs and reasonable attorney's

37 fees incurred by the person bringing the action.

38 (o) A defendant in a civil action brought under

39 Subsections (j) through (l) of this article is not

40 entitled to claim any privilege as a defense to the

41 action.

42 Revisor's Note

43 Section (j), V.T.I.C. Article 21.21-4, states

44 that a person may seek injunctive relief "in addition"

45 to a civil action. The revised law omits the quoted

46 language as unnecessary because an accepted principle

47 of statutory construction requires a statute to be

1 given cumulative effect with other statutes unless the
2 statute provides otherwise or unless the statutes are
3 in conflict.

4 Revised Law

5 Sec. 545.703. CRIMINAL PENALTY. (a) A person or entity
6 commits an offense if the person or entity, with criminal
7 negligence, violates Section 545.057 by:

8 (1) releasing or disclosing a test result or other
9 information; or

10 (2) allowing a test result or other information to
11 become known.

12 (b) An offense under this section is a Class A misdemeanor.

13 (c) Each release or disclosure made or allowance of a test
14 result to become known in violation of this chapter constitutes a
15 separate offense. (V.T.I.C. Art. 21.21-4, Secs. (m), (n).)

16 Source Law

17 (m)(1) A person or entity that, with criminal
18 negligence, releases or discloses a test result or
19 other information or that allows a test result or other
20 information to become known in violation of Subsection
21 (e) of this article commits an offense.

22 (2) An offense under this subsection is a
23 Class A misdemeanor.

24 (n) Each release or disclosure made or allowance
25 of a test result to become known in violation of this
26 article constitutes a separate offense.

27 CHAPTER 546. USE OF GENETIC TESTING INFORMATION

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14 CHAPTER 546. USE OF GENETIC TESTING INFORMATION

15 SUBCHAPTER A. GENERAL PROVISIONS

16 Revised Law

17 Sec. 546.001. DEFINITIONS. In this chapter:

18 (1) "DNA" means deoxyribonucleic acid.

19 (2) "Genetic characteristic" means a scientifically

20 or medically identifiable genetic or chromosomal variation,

21 composition, or alteration that predisposes an individual to a

22 disease, disorder, or syndrome.

23 (3) "Genetic information" means information that is:

24 (A) obtained from or based on a scientific or

25 medical determination of the presence or absence in an individual

26 of a genetic characteristic; or

27 (B) derived from the results of a genetic test

28 performed on an individual.

29 (4) "Genetic test" means a presymptomatic laboratory

30 test of an individual's genes, gene products, or chromosomes that:

31 (A) analyzes the individual's DNA, RNA,

32 proteins, or chromosomes; and

33 (B) is performed to identify any genetic

34 variation, composition, or alteration that is associated with the

1 individual's having a predisposition for:

2 (i) developing a clinically recognized
3 disease, disorder, or syndrome; or

4 (ii) being a carrier of a clinically
5 recognized disease, disorder, or syndrome.

6 The term does not include a blood test, cholesterol test,
7 urine test, or other physical test used for a purpose other than
8 determining a genetic or chromosomal variation, composition, or
9 alteration in a specific individual; a routine physical examination
10 or a routine test performed as part of a physical examination; a
11 test to determine drug use; or a test to determine the presence of
12 the human immunodeficiency virus.

13 (5) "RNA" means ribonucleic acid. (V.T.I.C. Art.
14 21.73, Secs. 1(1), (2), (3), (4), (6).)

15 Source Law

16 Art. 21.73

17 Sec. 1. In this article:

18 (1) "DNA" means deoxyribonucleic acid.

19 (2) "Genetic characteristic" means a
20 scientifically or medically identifiable genetic or
21 chromosomal variation, composition, or alteration
22 that predisposes an individual to a disease, disorder,
23 or syndrome.

24 (3) "Genetic information" means
25 information that is:

26 (A) obtained from or based on a
27 scientific or medical determination of the presence or
28 absence in an individual of a genetic characteristic;
29 or

30 (B) derived from the results of a
31 genetic test performed on that individual.

32 (4) "Genetic test" means a presymptomatic
33 laboratory test of an individual's genes, gene
34 products, or chromosomes to identify by analysis of
35 the individual's DNA, RNA, proteins, or chromosomes
36 genetic variations, compositions, or alterations that
37 are associated with a predisposition for a clinically
38 recognized disease, disorder, or syndrome or to be a
39 carrier of such a disease, disorder, or syndrome. The
40 term does not include:

41 (A) a blood test, cholesterol test,
42 urine test, or other physical test used for a purpose
43 other than determining a genetic or chromosomal
44 variation, composition, or alteration in a specific
45 individual;

46 (B) a routine physical examination or
47 a routine test performed as a part of a physical
48 examination;

49 (C) a test to determine drug use; or

50 (D) a test for the presence of the
51 human immunodeficiency virus.

1 (6) "RNA" means ribonucleic acid.

2 Revisor's Note

3 Section 1(5), V.T.I.C. Article 21.73, defines
4 "group health benefit plan." The revised law omits
5 this definition as unnecessary because Section 2,
6 V.T.I.C. Article 21.73, revised as Sections 546.002
7 and 546.003, specifies the types of group health
8 benefit plans to which the chapter applies, and thus
9 the defined term is not helpful to the reader. The
10 omitted law reads:

11 (5) "Group health benefit plan"
12 means a plan described by Section 2 of this
13 article.

14 Revised Law

15 Sec. 546.002. APPLICABILITY OF CHAPTER. This chapter
16 applies only to a group health benefit plan that:

17 (1) provides benefits for medical or surgical expenses
18 incurred as a result of a health condition, accident, or sickness,
19 including:

20 (A) a group, blanket, or franchise insurance
21 policy or insurance agreement, a group hospital service contract,
22 or a group evidence of coverage that is offered by:

23 (i) an insurance company;

24 (ii) a group hospital service corporation
25 operating under Chapter 842;

26 (iii) a fraternal benefit society operating
27 under Chapter 885;

28 (iv) a stipulated premium company operating
29 under Chapter 884; or

30 (v) a health maintenance organization
31 operating under Chapter 843; and

32 (B) to the extent permitted by the Employee
33 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et
34 seq.), a group health benefit plan that is offered by:

35 (i) a multiple employer welfare arrangement

1 as defined by Section 3 of that Act;

2 (ii) another entity not authorized under
3 this code or another insurance law of this state that directly
4 contracts for health care services on a risk-sharing basis,
5 including a capitation basis; or

6 (iii) another analogous benefit
7 arrangement; or

8 (2) is offered by an approved nonprofit health
9 corporation that holds a certificate of authority under Chapter
10 844. (V.T.I.C. Art. 21.73, Sec. 2(a).)

11 Source Law

12 Sec. 2. (a) This article applies to a group
13 health benefit plan that:

14 (1) provides benefits for medical or
15 surgical expenses incurred as a result of a health
16 condition, accident, or sickness, including:

17 (A) a group, blanket, or franchise
18 insurance policy or insurance agreement, a group
19 hospital service contract, or a group evidence of
20 coverage that is offered by:

21 (i) an insurance company;

22 (ii) a group hospital service
23 corporation operating under Chapter 20 of this code;

24 (iii) a fraternal benefit
25 society operating under Chapter 10 of this code;

26 (iv) a stipulated premium
27 insurance company operating under Chapter 22 of this
28 code; or

29 (v) a health maintenance
30 organization operating under the Texas Health
31 Maintenance Organization Act (Chapter 20A, Vernon's
32 Texas Insurance Code); or

33 (B) to the extent permitted by the
34 Employee Retirement Income Security Act of 1974 (29
35 U.S.C. Section 1001 et seq.), a group health benefit
36 plan that is offered by:

37 (i) a multiple employer welfare
38 arrangement as defined by Section 3, Employee
39 Retirement Income Security Act of 1974 (29 U.S.C.
40 Section 1002);

41 (ii) any other entity not
42 licensed under this code or another insurance law of
43 this state that contracts directly for health care
44 services on a risk-sharing basis, including an entity
45 that contracts for health care services on a
46 capitation basis; or

47 (iii) another analogous benefit
48 arrangement; or

49 (2) is offered by an approved nonprofit
50 health corporation that is certified under Section
51 5.01(a), Medical Practice Act (Article 4495b, Vernon's
52 Texas Civil Statutes), and that holds a certificate of
53 authority issued by the commissioner under Article
54 21.52F of this code.

1 Revisor's Note

2 (1) Section 2(a)(1)(B)(ii), V.T.I.C. Article
3 21.73, refers to a health benefit plan offered by an
4 entity not "licensed" under this code or "another
5 insurance law of this state." The revised law
6 substitutes "authorized" for "licensed" for
7 consistency with terminology used throughout this
8 code.

9 (2) Section 2(a)(2), V.T.I.C. Article 21.73,
10 refers to an approved nonprofit health corporation
11 that is "certified under Section 5.01(a), Medical
12 Practice Act," and holds a certificate of authority
13 "issued by the commissioner under Article 21.52F."
14 The reference in Article 21.73 to certification under
15 Section 5.01(a), Medical Practice Act (Article 4495b,
16 Vernon's Texas Civil Statutes), which was codified in
17 1999 in Chapter 162, Occupations Code, is unnecessary
18 because V.T.I.C. Article 21.52F, revised as Chapter
19 844 of this code, requires a nonprofit corporation to
20 be certified under that provision as a condition of
21 holding a certificate of authority. The reference to
22 the commissioner's issuing the certificate of
23 authority is also unnecessary because Article 21.52F,
24 as revised, requires the commissioner to issue the
25 certificate of authority.

26 Revised Law

27 Sec. 546.003. EXCEPTIONS. This chapter does not apply to:

- 28 (1) a plan that provides coverage:
- 29 (A) only for a specified disease;
 - 30 (B) only for accidental death or dismemberment;
 - 31 (C) for wages or payments in lieu of wages for a
32 period during which an employee is absent from work because of
33 sickness or injury; or
 - 34 (D) as a supplement to liability insurance;

1 (2) a Medicare supplemental policy as defined by
2 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

3 (3) workers' compensation insurance coverage;

4 (4) medical payment insurance coverage provided under
5 a motor vehicle insurance policy; or

6 (5) a long-term care policy, including a nursing home
7 fixed indemnity policy, unless the commissioner determines that the
8 policy provides benefit coverage so comprehensive that the policy
9 is a group health benefit plan as described by Section 546.002.
10 (V.T.I.C. Art. 21.73, Sec. 2(b).)

11 Source Law

12 (b) This article does not apply to:

13 (1) a plan that provides coverage:

14 (A) only for a specified disease;

15 (B) only for accidental death or
16 dismemberment;

17 (C) for wages or payments in lieu of
18 wages for a period during which an employee is absent
19 from work because of sickness or injury; or

20 (D) as a supplement to liability
21 insurance;

22 (2) a Medicare supplemental policy as
23 defined by Section 1882(g)(1), Social Security Act (42
24 U.S.C. Section 1395ss);

25 (3) workers' compensation insurance
26 coverage;

27 (4) medical payment insurance issued as
28 part of a motor vehicle insurance policy; or

29 (5) a long-term care policy, including a
30 nursing home fixed indemnity policy, unless the
31 commissioner determines that the policy provides
32 benefit coverage so comprehensive that the policy is a
33 group health benefit plan as described by Subsection
34 (a) of this section.

35 [Sections 546.004-546.050 reserved for expansion]

36 SUBCHAPTER B. GENETIC TESTING AND USE OF TEST RESULTS

37 Revised Law

38 Sec. 546.051. CERTAIN TESTING PERMITTED; INDUCEMENT
39 PROHIBITED. (a) A group health benefit plan issuer that requests
40 an applicant for coverage under the plan to submit to a genetic test
41 in connection with the application for coverage for a purpose not
42 prohibited under Section 546.052 must:

43 (1) notify the applicant that the test is required;

44 (2) disclose to the applicant the proposed use of the
45 test results; and

1 (3) obtain the applicant's written informed consent
2 before the test is administered.

3 (b) The applicant shall state in the consent form whether
4 the applicant elects to be informed of the test results. If the
5 applicant elects to be informed, the person or entity that performs
6 the test shall disclose the test results to the applicant and the
7 group health benefit plan issuer. The issuer shall ensure that:

8 (1) the applicant receives an interpretation of the
9 test results made by a qualified health care practitioner; and

10 (2) a physician or other health care practitioner
11 designated by the applicant receives a copy of the test results.

12 (c) A group health benefit plan issuer may not use the
13 results of a genetic test conducted in accordance with Subsection
14 (a) to induce the purchase of coverage under the plan. (V.T.I.C.
15 Art. 21.73, Secs. 3(b), (c), (d).)

16 Source Law

17 (b) If a group health benefit plan issuer
18 requests that an applicant for coverage under the plan
19 submit to a genetic test in connection with the
20 application for coverage for a purpose other than a
21 purpose prohibited under Subsection (a) of this
22 section, the issuer must:

23 (1) notify the applicant that the test is
24 required;

25 (2) disclose to the applicant the proposed
26 use of the test results; and

27 (3) obtain the applicant's written
28 informed consent for the test before the
29 administration of the test.

30 (c) In the consent form, the applicant shall
31 state whether the applicant elects to be informed of
32 the results of the test. If the applicant does so
33 elect, the person or entity that performs the test
34 shall disclose the results of the test to the
35 applicant, as well as to the group health benefit plan
36 issuer, and the group health benefit plan issuer shall
37 ensure that:

38 (1) the applicant receives an
39 interpretation of the test results made by a qualified
40 health care practitioner; and

41 (2) a physician or other health care
42 practitioner designated by the applicant receives a
43 copy of the results of the test.

44 (d) A group health benefit plan issuer may not
45 use the results of a genetic test conducted in
46 accordance with Subsection (b) of this section as an
47 inducement for the purchase of coverage under the
48 plan.

1 Revised Law

2 Sec. 546.052. IMPROPER USE OF TEST RESULTS; REFUSAL TO
3 SUBMIT TO TESTING. A group health benefit plan issuer may not use
4 genetic information or the refusal of an applicant to submit to a
5 genetic test to reject, deny, limit, cancel, refuse to renew,
6 increase the premiums for, or otherwise adversely affect
7 eligibility for or coverage under the plan. (V.T.I.C. Art. 21.73,
8 Secs. 3(a), (e).)

9 Source Law

10 Sec. 3. (a) A group health benefit plan issuer
11 may not use genetic information to reject, deny,
12 limit, cancel, refuse to renew, increase the premiums
13 for, or otherwise adversely affect eligibility for or
14 coverage under the group health benefit plan.

15 (e) A group health benefit plan issuer may not
16 use the refusal of an applicant to submit to a genetic
17 test to reject, deny, limit, cancel, refuse to renew,
18 increase the premiums for, or otherwise adversely
19 affect eligibility for or coverage under the group
20 health benefit plan.

21 Revised Law

22 Sec. 546.053. TESTING RELATED TO PREGNANCY. (a) In this
23 section, "coerce" means to restrain or dominate a woman's free will
24 by actual or implied:

25 (1) force; or

26 (2) threat of rejecting, denying, limiting,
27 canceling, refusing to renew, or otherwise adversely affecting
28 eligibility for coverage under a group health benefit plan.

29 (b) A group health benefit plan issuer may not:

30 (1) require as a condition of coverage genetic testing
31 of a child in utero without the pregnant woman's consent; or

32 (2) use genetic information to coerce or compel a
33 pregnant woman to have an induced abortion. (V.T.I.C. Art. 21.73,
34 Sec. 8.)

35 Source Law

36 Sec. 8. (a) No issuer of a group health benefit
37 plan shall require, as a condition of insurance
38 coverage, genetic testing of a child in utero without
39 the consent of the pregnant woman.

40 (b) No issuer of a group health benefit plan
41 shall use genetic information to coerce or compel a

1 pregnant woman to have an induced abortion.

2 (c) "Coercion" for the purposes of this section
3 means the restraining or domination of the free will of
4 a woman by actual or implied force, or by actual or
5 implied threat of rejection, denial, limitation,
6 cancellation, refusal to renew, or otherwise adversely
7 affecting eligibility for coverage under a group
8 health benefit plan.

9 Revisor's Note

10 Section 8(a), V.T.I.C. Article 21.73, refers to
11 "insurance coverage." The revised law omits the
12 reference to "insurance" as inaccurate because Section
13 8 applies to coverage that is not insurance, such as
14 coverage provided by a health maintenance
15 organization.

16 Revised Law

17 Sec. 546.054. DESTRUCTION OF SAMPLE MATERIAL;
18 EXCEPTIONS. A sample of genetic material obtained from an
19 individual for a genetic test shall be destroyed promptly after the
20 purpose for which the sample was obtained is accomplished unless:

21 (1) the sample is retained under a court order;

22 (2) the individual authorizes retention of the sample
23 for medical treatment or scientific research;

24 (3) the sample was obtained for research that is
25 cleared by an institutional review board and retention of the
26 sample is:

27 (A) under a requirement the institutional review
28 board imposes on a specific research project; or

29 (B) authorized by the research participant with
30 institutional review board approval under federal law; or

31 (4) the sample was obtained for a screening test
32 established by the Texas Department of Health under Section 33.011,
33 Health and Safety Code, and performed by that department or a
34 laboratory approved by that department. (V.T.I.C. Art. 21.73, Sec.
35 6.)

36 Source Law

37 Sec. 6. A sample of genetic material taken for a
38 genetic test from an individual shall be destroyed
39 promptly after the purpose for which the sample was

1 obtained is accomplished unless:

2 (1) the sample is retained under a court
3 order;

4 (2) the individual tested authorizes
5 retention of the sample for purposes of medical
6 treatment or scientific research;

7 (3) for a sample obtained for research
8 that is cleared by an institutional review board, the
9 sample is retained under the requirements that the
10 institutional review board imposes on a specific
11 research project or as authorized by the research
12 participant with institutional review board approval
13 under federal law; or

14 (4) the sample was obtained for a
15 screening test established by the Texas Department of
16 Health and performed by that department or by a
17 laboratory approved by that department under Section
18 33.011, Health and Safety Code.

19 [Sections 546.055-546.100 reserved for expansion]

20 SUBCHAPTER C. DISCLOSURE OF GENETIC INFORMATION; CONFIDENTIALITY;

21 EXCEPTIONS

22 Revised Law

23 Sec. 546.101. DISCLOSURE OF TEST RESULTS TO INDIVIDUAL
24 TESTED. (a) An individual who submits to a genetic test has the
25 right to know the results of the test. On the written request by the
26 individual, the group health benefit plan issuer or other entity
27 that performed the test shall disclose the test results to:

28 (1) the individual; or

29 (2) a physician designated by the individual.

30 (b) The right to receive information under this section is
31 in addition to any right or requirement established under Sections
32 546.051 and 546.052. (V.T.I.C. Art. 21.73, Sec. 5.)

33 Source Law

34 Sec. 5. An individual who submits to a genetic
35 test has the right to know the results of that test. On
36 the written request of the individual, the group
37 health benefit plan issuer or other entity that
38 performed the test shall disclose the test results to
39 the individual or to a physician designated by the
40 individual. The right to information under this
41 section is in addition to any right or requirement
42 established under Section 3 of this article.

43 Revised Law

44 Sec. 546.102. CONFIDENTIALITY OF GENETIC INFORMATION. (a)
45 Except as provided by Sections 546.103(a) and (b), genetic
46 information is confidential and privileged regardless of the source
47 of the information.

1 (b) A person or entity that holds genetic information about
2 an individual may not disclose or be compelled to disclose, by
3 subpoena or otherwise, that information unless the disclosure is
4 specifically authorized by the individual as provided by Section
5 546.104.

6 (c) This section applies to a redisclosure of genetic
7 information by a secondary recipient of the information after
8 disclosure of the information by an initial recipient. Except as
9 provided by Section 546.103(b), a group health benefit plan issuer
10 may not redisclose genetic information unless the redisclosure is
11 consistent with the disclosures authorized by the tested individual
12 under an authorization executed under Section 546.104. (V.T.I.C.
13 Art. 21.73, Secs. 4(a), (d) (part).)

14 Source Law

15 Sec. 4. (a) Except as provided by Subsections
16 (c) and (d) of this section, genetic information is
17 confidential and privileged regardless of the source
18 of the information. A person or entity that holds that
19 information may not disclose or be compelled to
20 disclose, by subpoena or otherwise, genetic
21 information about an individual unless the disclosure
22 is specifically authorized by the individual as
23 provided by Subsection (b) of this section. This
24 subsection applies to a redisclosure of genetic
25 information by a secondary recipient of the
26 information after disclosure of the information by an
27 initial recipient.

28 (d) Except as provided by this subsection, a
29 group health benefit plan issuer may not redisclose
30 genetic information unless the redisclosure is
31 consistent with the disclosures authorized by the
32 tested individual under an authorization form executed
33 under Subsection (b) of this section. . . .

34 Revised Law

35 Sec. 546.103. EXCEPTIONS TO CONFIDENTIALITY. (a) Subject
36 to Subchapter G, Chapter 411, Government Code, genetic information
37 may be disclosed without an authorization under Section 546.104 if
38 the disclosure is:

39 (1) authorized under a state or federal criminal law
40 relating to:

41 (A) the identification of individuals; or

42 (B) a criminal or juvenile proceeding, an

1 inquest, or a child fatality review by a multidisciplinary
2 child-abuse team;

3 (2) required under a specific order of a state or
4 federal court;

5 (3) for the purpose of establishing paternity as
6 authorized under a state or federal law;

7 (4) made to provide genetic information relating to a
8 decedent and the disclosure is made to the blood relatives of the
9 decedent for medical diagnosis; or

10 (5) made to identify a decedent.

11 (b) A group health benefit plan issuer may redisclose
12 genetic information without an authorization under Section
13 546.104:

14 (1) for actuarial or research studies if:

15 (A) a tested individual could not be identified
16 in any actuarial or research report; and

17 (B) any materials that identify a tested
18 individual are returned or destroyed as soon as reasonably
19 practicable;

20 (2) to the department for the purpose of enforcing
21 this chapter; or

22 (3) for a purpose directly related to enabling a
23 business decision to be made about:

24 (A) purchasing, transferring, merging, or
25 selling all or part of an insurance business; or

26 (B) obtaining reinsurance affecting that
27 insurance business.

28 (c) A redisclosure authorized under Subsection (b) may
29 contain only information reasonably necessary to accomplish the
30 purpose for which the information is disclosed. (V.T.I.C. Art.
31 21.73, Secs. 4(c), (d) (part), (e).)

32 Source Law

33 (c) Subject to Subchapter G, Chapter 411,
34 Government Code, genetic information relating to an
35 individual may be disclosed without the authorization

1 required under Subsection (b) of this section if the
2 disclosure is:

3 (1) authorized under a state or federal
4 criminal law relating to:

5 (A) the identification of
6 individuals; or

7 (B) a criminal or juvenile
8 proceeding, an inquest, or a child fatality review by a
9 multidisciplinary child-abuse team;

10 (2) required under a specific order of a
11 state or federal court;

12 (3) authorized under a state or federal
13 law to establish paternity;

14 (4) made to furnish genetic information
15 relating to a decedent to the blood relatives of the
16 decedent for the purpose of medical diagnosis; or

17 (5) made to identify a decedent.

18 (d) . . . A group health benefit plan issuer
19 may redisclose genetic information:

20 (1) for actuarial or research studies if:

21 (A) a tested individual may not be
22 identified in any actuarial or research report; and

23 (B) any materials that identify a
24 tested individual are returned or destroyed as soon as
25 reasonably practicable;

26 (2) to the department for the purposes of
27 the enforcement of this article; or

28 (3) for purposes directly related to
29 enabling business decisions to be made about the
30 purchase, transfer, merger, or sale of all or part of
31 an insurance business or about obtaining reinsurance
32 affecting that insurance business.

33 (e) A redisclosure authorized under Subsection
34 (d) of this section may contain only information
35 reasonably necessary to accomplish the purpose for
36 which the information is disclosed.

37 Revised Law

38 Sec. 546.104. AUTHORIZED DISCLOSURE. An individual or an
39 individual's legal representative may authorize disclosure of
40 genetic information relating to the individual by an authorization
41 that:

42 (1) is written in plain language;

43 (2) is dated;

44 (3) contains a specific description of the information
45 to be disclosed;

46 (4) identifies or describes each person authorized to
47 disclose the genetic information to a group health benefit plan
48 issuer;

49 (5) identifies or describes the individuals or
50 entities to whom the disclosure or subsequent redisclosure of the
51 genetic information may be made;

52 (6) describes the specific purpose of the disclosure;

1 (7) is signed by the individual or legal
2 representative and, if the disclosure is made to claim proceeds of
3 an affected life insurance policy, the claimant; and

4 (8) advises the individual or legal representative
5 that the individual's authorized representative is entitled to
6 receive a copy of the authorization. (V.T.I.C. Art. 21.73, Sec.
7 4(b).)

8 Source Law

9 (b) An individual or the legal representative of
10 an individual may authorize the disclosure of genetic
11 information relating to that individual through an
12 authorization that:

13 (1) is written in plain language;

14 (2) is dated;

15 (3) contains a specific description of the
16 information to be disclosed;

17 (4) identifies or describes each person
18 authorized to disclose the genetic information to a
19 group health benefit plan issuer;

20 (5) identifies or describes the
21 individuals or entities to whom the disclosure or
22 subsequent redisclosure of the genetic information may
23 be made;

24 (6) describes the specific purpose of the
25 disclosure;

26 (7) is signed by the individual or the
27 legal representative and, if the disclosure is for
28 claiming proceeds of any affected life insurance
29 policy, the claimant; and

30 (8) advises the individual or legal
31 representative that the individual's authorized
32 representative is entitled to receive a copy of the
33 authorization form.

34 [Sections 546.105-546.150 reserved for expansion]

35 SUBCHAPTER D. ENFORCEMENT

36 Revised Law

37 Sec. 546.151. CEASE AND DESIST ORDER. (a) On a finding by
38 the commissioner that a group health benefit plan issuer is in
39 violation of this chapter, the commissioner may issue a cease and
40 desist order in the manner provided by Chapter 83.

41 (b) If a group health benefit plan issuer refuses or fails
42 to comply with a cease and desist order issued under this section,
43 the commissioner may, in the manner provided by this code and other
44 insurance laws of this state, revoke or suspend the issuer's
45 certificate of authority or other authorization to operate a group
46 health benefit plan in this state. (V.T.I.C. Art. 21.73, Sec.

1 7(a).)

2 Source Law

3 Sec. 7. (a) On a finding by the commissioner
4 that a group health benefit plan issuer is in violation
5 of this article, the commissioner may enter a cease and
6 desist order in the manner provided under Article
7 1.10A of this code. If the group health benefit plan
8 issuer refuses or fails to comply with the cease and
9 desist order, the commissioner may, in the manner
10 provided by this code and the other insurance laws of
11 this state, revoke or suspend the issuer's certificate
12 of authority or other authorization to engage in the
13 operation of a group health benefit plan in this state.

14 Revised Law

15 Sec. 546.152. ADMINISTRATIVE PENALTY. A group health
16 benefit plan issuer that operates a plan in violation of this
17 chapter is subject to an administrative penalty as provided by
18 Chapter 84. (V.T.I.C. Art. 21.73, Sec. 7(b).)

19 Source Law

20 (b) A group health benefit plan issuer that
21 operates the plan in violation of this article is
22 subject to an administrative penalty as provided by
23 Article 1.10E of this code.

24 CHAPTER 547. FALSE ADVERTISING BY UNAUTHORIZED INSURERS

25 SUBCHAPTER A. GENERAL PROVISIONS

26 Sec. 547.001. DEFINITIONS 360
27 Sec. 547.002. CONSTRUCTION OF CHAPTER 362

28 [Sections 547.003-547.050 reserved for expansion]

29 SUBCHAPTER B. PROHIBITION; ENFORCEMENT

30 Sec. 547.051. ACTS PROHIBITED 362
31 Sec. 547.052. NOTICE OF VIOLATION TO INSURER'S
32 DOMICILIARY STATE 363
33 Sec. 547.053. ENFORCEMENT ACTION 363

34 CHAPTER 547. FALSE ADVERTISING BY UNAUTHORIZED INSURERS

35 SUBCHAPTER A. GENERAL PROVISIONS

36 Revised Law

37 Sec. 547.001. DEFINITIONS. In this chapter:

38 (1) "Alien or foreign insurer" means an insurance
39 company organized under the laws of:

40 (A) a country other than the United States; or

1 (B) a state of the United States other than this
2 state.

3 (2) "Resident" includes a domestic, alien, or foreign:

4 (A) corporation;

5 (B) partnership; or

6 (C) person. (V.T.I.C. Art. 21.21-1, Secs. 2(a),

7 (c).)

8 Source Law

9 Sec. 2. (a) The term "foreign or alien insurer"
10 shall mean any insurance company organized under the
11 laws of any other state or territory of the United
12 States or any foreign country.

13 (c) "Residents" shall mean and include person,
14 partnership or corporation, domestic, alien or
15 foreign.

16 Revisor's Note

17 (1) Section 2(a), V.T.I.C. Article 21.21-1,
18 refers to a "state or territory of the United States or
19 any foreign country." The revised law omits as
20 unnecessary the reference to "territory" because the
21 term is included in the definition of "state" provided
22 by Section 311.005(7), Government Code (Code
23 Construction Act), applicable to the revised law.

24 (2) The revised law omits Section 2(b), V.T.I.C.
25 Article 21.21-1, as unnecessary. The subsection
26 defines the term "Unfair Trade Practice Act," used in
27 Sections 3 and 4 of Article 21.21-1, to mean Chapter
28 198, Acts of the 55th Legislature, Regular Session,
29 1957 (V.T.I.C. Article 21.21). V.T.I.C. Article 21.21
30 is revised in Chapter 541 of this code, and this
31 chapter substitutes references to that chapter for
32 references to the Unfair Trade Practice Act. The
33 omitted subsection reads:

34 (b) "Unfair Trade Practice Act" shall
35 mean the Act of 1957, 55th Legislature, page
36 401, Chapter 198, also known as Article
37 21.21 of the Insurance Code.

1 Revised Law

2 Sec. 547.002. CONSTRUCTION OF CHAPTER. This chapter shall
3 be construed liberally. (V.T.I.C. Art. 21.21-1, Sec. 1(b).)

4 Source Law

5 (b) The provisions of this Act shall be
6 liberally construed.

7 [Sections 547.003-547.050 reserved for expansion]

8 SUBCHAPTER B. PROHIBITION; ENFORCEMENT

9 Revised Law

10 Sec. 547.051. ACTS PROHIBITED. (a) This section applies
11 only to an insurer's misrepresentation of:

12 (1) the insurer's financial condition;

13 (2) the terms of an existing or future contract;

14 (3) the benefits or advantages promised by an existing
15 or future contract; or

16 (4) the dividends or share of surplus to be received on
17 an existing or future contract.

18 (b) An unauthorized alien or foreign insurer may not:

19 (1) make, issue, circulate, or cause to be made,
20 issued, or circulated to a resident of this state a
21 misrepresentation in an advertisement, estimate, illustration,
22 circular, pamphlet, or letter that violates Chapter 541; or

23 (2) cause to be made to a resident of this state in a
24 newspaper, magazine, or other publication, or over a radio or
25 television station, a misrepresentation in an announcement or
26 statement that violates Chapter 541. (V.T.I.C. Art. 21.21-1, Sec.
27 3 (part).)

28 Source Law

29 Sec. 3. No unauthorized foreign or alien insurer
30 shall make, issue, circulate or cause to be made,
31 issued or circulated, to residents of this state any
32 advertisement, estimate, illustration, circular,
33 pamphlet, or letter, or cause to be made in any
34 newspaper, magazine or other publication or over any
35 radio or television station, any announcement or
36 statement to such residents misrepresenting its
37 financial condition or the terms of any contracts
38 issued or to be issued or the benefits or advantages
39 promised thereby, or the dividends or share of the
40 surplus to be received thereon in violation of the

1 Unfair Trade Practice Act, and

2 Revised Law

3 Sec. 547.052. NOTICE OF VIOLATION TO INSURER'S DOMICILIARY
4 STATE. (a) In this section, the domiciliary state of an alien
5 insurer is the state of entry or the state of the insurer's
6 principal office in the United States.

7 (b) If the department has reason to believe that an insurer
8 has engaged in an act prohibited by Section 547.051, the department
9 shall notify, by registered mail, the insurer and the insurance
10 supervisory official of the insurer's domiciliary state. (V.T.I.C.
11 Art. 21.21-1, Sec. 3 (part).)

12 Source Law

13 Sec. 3. . . . whenever the State Board of
14 Insurance shall have reason to believe that any such
15 insurer is engaging in such unlawful advertising, it
16 shall be its duty to give notice of such fact by
17 registered mail to such insurer and to the insurance
18 supervisory official of the domiciliary state of such
19 insurer. For the purpose of this Section, the
20 domiciliary state of an alien insurer shall be deemed
21 to be the state of entry or the state of the principal
22 office in the United States.

23 Revised Law

24 Sec. 547.053. ENFORCEMENT ACTION. The department shall
25 take action under Chapter 541 against an insurer notified under
26 Section 547.052 if:

27 (1) after the 30th day following the date of notice,
28 the insurer has not stopped making, issuing, or circulating or
29 causing to be made, issued, or circulated in this state the false
30 misrepresentations; and

31 (2) the department has reason to believe that:

32 (A) the insurer is issuing or delivering
33 insurance contracts to residents of this state or is collecting
34 premiums on those contracts; and

35 (B) a department proceeding regarding the
36 misrepresentations is in the public interest. (V.T.I.C. Art.
37 21.21-1, Sec. 4.)

38 Source Law

39 Sec. 4. If after thirty (30) days following the

1 giving of the notice mentioned in Section 3 such
2 insurer has failed to cease making, issuing, or
3 circulating such false misrepresentations or causing
4 the same to be made, issued or circulated in this
5 state, and if the State Board of Insurance has reason
6 to believe that a proceeding by it in respect to such
7 matters would be to the interest of the public, and
8 that such insurer is issuing or delivering contracts
9 of insurance to residents of this state or collecting
10 premiums on such contracts or doing any of the acts
11 enumerated in Section 5, the said Board shall take
12 action against such insurer under the Unfair Trade
13 Practice Act.

14 Revisor's Note

15 Section 4, V.T.I.C. Article 21.21-1, provides a
16 duty for the Texas Department of Insurance to take an
17 action against an insurer if the department has reason
18 to believe that the insurer is "doing any of the acts
19 enumerated in Section 5 [of V.T.I.C. Article
20 21.21-1]." The revised law omits the quoted language
21 as obsolete because Section 5, V.T.I.C. Article
22 21.21-1, was repealed by Chapter 46, Acts of the 70th
23 Legislature, Regular Session, 1987.

24 Revisor's Note
25 (End of Chapter)

26 (1) V.T.I.C. Article 21.21-1, as enacted by
27 Chapter 122, Acts of the 57th Legislature, Regular
28 Session, 1961, was concerned primarily with substitute
29 service of process on unauthorized insurers. Section
30 5 of the article, which provided for substitute
31 service of process on unauthorized insurers, was
32 repealed by Chapter 46, Acts of the 70th Legislature,
33 Regular Session, 1987. That repeal made the article's
34 purpose clause (Section 1(a) of the article) and short
35 title (Section 7 of the article) misleading in the
36 context of the remaining text of the article.
37 Consequently, the revised law omits the purpose clause
38 as obsolete and executed and omits the short title as
39 obsolete. The omitted law reads:

40 Art. 21.21-1
41 Sec. 1. (a) The purpose of this Act
42 is to subject to the jurisdiction of the

1 State Board of Insurance of this state and
2 to the jurisdiction of the courts of this
3 state insurers not authorized to transact
4 business in this state which place in or
5 send into this state any false advertising
6 designed to induce residents of this state
7 to purchase insurance from insurers not
8 authorized to transact business in this
9 state. The Legislature declares it is in
10 the interest of the citizens of this state
11 who purchase insurance from insurers which
12 solicit insurance business in this state in
13 the manner set forth in the preceding
14 sentence that such insurers be subject to
15 the provisions of this Act. In furtherance
16 of such state interest, the Legislature
17 herein provides a method of substituted
18 service of process upon such insurers and
19 declares that in so doing, it exercises its
20 powers to protect its residents and also
21 exercises powers and privileges available
22 to the state by virtue of Public Law 15,
23 79th Congress of the United States, Chapter
24 20, 1st Session, S. 340, which declares that
25 the business of insurance and every person
26 engaged therein shall be subject to the laws
27 of the several states; the authority
28 provided herein to be in addition to any
29 existing powers of this state.

30 Sec. 7. This Act may be cited as the
31 Unauthorized Insurers False Advertising
32 Process Act.

33 (2) The revised law omits Section 6, V.T.I.C.
34 Article 21.21-1, regarding the severability of the
35 article's provisions, because the section duplicates
36 Section 311.032, Government Code (Code Construction
37 Act), providing for the severability of statutes. The
38 omitted law reads:

39 Sec. 6. If any provision of this Act
40 or the application of such provision to any
41 person or circumstance shall be held
42 invalid, the remainder of the Act, and the
43 application of such provision to persons or
44 circumstances other than those as to which
45 it is held invalid, shall not be affected
46 thereby.

47 CHAPTER 548. INSURER INSIDER TRADING AND PROXY REGULATION

48 SUBCHAPTER A. GENERAL PROVISIONS

49 Sec. 548.001. PURPOSE 366
50 Sec. 548.002. DEFINITIONS 368
51 Sec. 548.003. RULEMAKING AUTHORITY 370
52 Sec. 548.004. RULES RELATING TO EQUITY SECURITIES AND EXEMPT
53 SECURITIES 370

1 [Sections 548.005-548.100 reserved for expansion]

2 SUBCHAPTER B. REQUIRED ACTS; PROHIBITIONS

3 Sec. 548.101. DEFINITION 372

4 Sec. 548.102. STATEMENT OF BENEFICIAL OWNERSHIP OF EQUITY

5 SECURITIES 372

6 Sec. 548.103. RECOVERY OF CERTAIN PROFITS 373

7 Sec. 548.104. SALE OR NONDELIVERY OF CERTAIN EQUITY SECURITIES

8 PROHIBITED 376

9 Sec. 548.105. CERTAIN SOLICITATIONS PROHIBITED; DISCLOSURE

10 BY INSURER 377

11 Sec. 548.106. NONAPPLICABILITY OF SUBCHAPTER 378

12 [Sections 548.107-548.200 reserved for expansion]

13 SUBCHAPTER C. ENFORCEMENT

14 Sec. 548.201. OFFENSES; CRIMINAL PENALTY 380

15 Sec. 548.202. CIVIL PENALTY 381

16 Sec. 548.203. INJUNCTIVE ACTION 382

17 CHAPTER 548. INSURER INSIDER TRADING AND PROXY REGULATION

18 SUBCHAPTER A. GENERAL PROVISIONS

19 Revised Law

20 Sec. 548.001. PURPOSE. (a) The purpose of this chapter is

21 to provide for protection of the public interest, investors, and

22 shareholders of domestic stock insurers by:

23 (1) regulating proxy solicitation by domestic stock

24 insurers;

25 (2) regulating transactions by officers, directors,

26 and principal equity security holders of domestic stock insurers;

27 and

28 (3) requiring appropriate reporting of those

29 solicitations and transactions.

30 (b) To that end the misuse of information by certain

31 insiders of domestic stock insurers shall be prevented and a full

32 and fair disclosure of all material matters relevant to the

33 exercise of the corporate franchise of a shareholder of such an

34 insurer will be promoted and the free exercise of that franchise

1 will be assured.

2 (c) In exercising the authority granted by this chapter to
3 adopt rules, the commissioner shall promote the purposes of this
4 chapter to prevent misuse of information and to encourage good
5 faith dealing and full and fair disclosure. (V.T.I.C. Art. 21.48,
6 Sec. 13.)

7 Source Law

8 Sec. 13. It is the purpose of this Article to
9 provide for the protection of the public interest, the
10 investor, and the shareholder of domestic stock
11 insurance companies by regulating proxy solicitation
12 by domestic stock insurance companies and transactions
13 by officers, directors and principal equity security
14 holders of such companies and requiring appropriate
15 reports thereof. To this end the misuse of information
16 by certain insiders of domestic stock insurance
17 companies shall be prevented and a full and fair
18 disclosure of all material matters relevant to the
19 exercise of the corporate franchise of a shareholder
20 of such companies will be promoted and the free
21 exercise of such franchise will be insured. In
22 exercising the authority granted by this Article to
23 make rules and regulations the Board shall promote the
24 purposes of this Article to prevent misuse of
25 information and to encourage good faith dealing and
26 full and fair disclosure.

27 Revisor's Note

28 (1) Section 13 and other provisions of V.T.I.C.
29 Article 21.48 refer to "rules and regulations."
30 Throughout this chapter, the revised law omits
31 references to "regulations" in this context because
32 under Section 311.005(5), Government Code (Code
33 Construction Act), a rule is defined to include a
34 regulation. That definition applies to the revised
35 law.

36 (2) Section 13, V.T.I.C. Article 21.48, refers
37 to "the Board," meaning the State Board of Insurance.
38 Chapter 685, Acts of the 73rd Legislature, Regular
39 Session, 1993, abolished the State Board of Insurance
40 and transferred its functions to the commissioner of
41 insurance and the Texas Department of Insurance, as
42 appropriate. Throughout this chapter, references to
43 the State Board of Insurance have been changed

1 appropriately.

2 Revised Law

3 Sec. 548.002. DEFINITIONS. In this chapter:

4 (1) "Domestic stock insurer" includes a domestic
5 title insurance company regulated by Title 11 and a stipulated
6 premium company regulated by Chapter 884.

7 (2) "Equity security" means:

8 (A) a stock or similar security;

9 (B) a security that:

10 (i) is convertible, with or without
11 consideration, into an equity security; or

12 (ii) carries a warrant or right to
13 subscribe to or purchase an equity security;

14 (C) a warrant or right to subscribe to or
15 purchase an equity security; or

16 (D) any other security defined as an equity
17 security in accordance with Section 548.004(a)(1).

18 (3) "Federal Securities Exchange Act" means the
19 Securities Exchange Act of 1934 (15 U.S.C. Section 77b et seq.), as
20 amended.

21 (4) "Officer" means:

22 (A) a president, vice president, treasurer,
23 actuary, secretary, or controller of a domestic stock insurer; or

24 (B) any other person who performs for a domestic
25 stock insurer the functions of an officer described by Paragraph
26 (A).

27 (5) "Person" means an individual, corporation,
28 partnership, association, joint-stock company, business trust, or
29 unincorporated organization. (V.T.I.C. Art. 21.48, Secs. 8(3), (4)
30 (part), (6), (7); New.)

31 Source Law

32 (3) "Person" shall mean an individual, a
33 corporation, a partnership, an association, a
34 joint-stock company, a business trust, or an
35 unincorporated organization;

36 (4) "Equity security" shall mean any stock

1 or similar security; or any security convertible, with
2 or without consideration, into such a security, or
3 carrying any warrant or right to subscribe to or
4 purchase such a security; or any such warrant or right;
5 or any other security which the Board shall deem . . .
6 to treat as an equity security;

7 (6) "Officer" shall mean a president,
8 vice-president, treasurer, actuary, secretary,
9 controller, and any other person who performs for a
10 domestic stock insurance company functions
11 corresponding to those performed by the foregoing
12 officers.

13 (7) Without limiting the generality
14 thereof, the term "stock insurance company" shall
15 include domestic title insurance companies, regulated
16 by Chapter 9 of the Texas Insurance Code, and
17 stipulated premium insurance companies, regulated by
18 Chapter 22 of the Texas Insurance Code.

19 Revisor's Note

20 (1) Section 8(1), V.T.I.C. Article 21.48,
21 defines "board" as the State Board of Insurance, and
22 Section 8(2), V.T.I.C. Article 21.48, defines
23 "commissioner" as the commissioner of insurance. As
24 explained in Revisor's Note (2) to Section 548.001, the
25 State Board of Insurance has been abolished, and
26 consequently the revised law omits the definition of
27 "board." The revised law also omits the definition of
28 "commissioner" as unnecessary. Section 31.001 of this
29 code defines "commissioner" for purposes of this code
30 and the other insurance laws of this state to mean the
31 commissioner of insurance. The omitted law reads:

32 Sec. 8. When used in this Article:

33 (1) "Board" means the State
34 Board of Insurance;

35 (2) "Commissioner" means the
36 Commissioner of Insurance;

37 . . .

38 (2) Section 8(7), V.T.I.C. Article 21.48,
39 states that "[w]ithout limiting the generality
40 thereof," a stock insurance company includes certain
41 insurers. The revised law omits the quoted language as
42 unnecessary because Section 311.005(13), Government
43 Code (Code Construction Act), applicable to the
44 revised law, provides that "includes" and "including"
45 are terms of enlargement and not of limitation and do

1 not create a presumption that components not expressed
2 are excluded. The revised law substitutes "domestic
3 stock insurer" for "stock insurance company" for
4 consistency with the terminology used in this chapter.

5 (3) The revised law adds the definition of
6 "federal Securities Exchange Act" for drafting
7 convenience and to eliminate frequent, unnecessary
8 repetition of the substance of the definition.

9 Revised Law

10 Sec. 548.003. RULEMAKING AUTHORITY. The commissioner may:

11 (1) adopt rules necessary for the execution of the
12 powers and duties of the department or commissioner under this
13 subchapter and Subchapter B; and

14 (2) for that purpose classify domestic stock insurers,
15 securities, and other persons or matters under the jurisdiction of
16 the department or commissioner. (V.T.I.C. Art. 21.48, Sec. 10
17 (part).)

18 Source Law

19 Sec. 10. The State Board of Insurance shall have
20 the power to make such rules and regulations as may be
21 necessary for the execution of the functions vested in
22 it by Sections 2 through 9 of this Article, and may for
23 such purpose classify domestic stock insurance
24 companies, securities, and other persons or matters
25 within its jurisdiction. . . .

26 Revised Law

27 Sec. 548.004. RULES RELATING TO EQUITY SECURITIES AND
28 EXEMPT SECURITIES. (a) If the commissioner considers it necessary
29 or appropriate in the public interest or for the protection of
30 investors, the commissioner by rule may define:

31 (1) "equity security" to include a security that is
32 similar in nature to an equity security; and

33 (2) "exempt security" for purposes of this chapter.

34 (b) In adopting a rule under Subsection (a)(2), the
35 commissioner may define the term conditionally, on specified terms,
36 or for a stated period. (V.T.I.C. Art. 21.48, Secs. 8(4) (part),
37 (5).)

1 Source Law

2 (4) ["Equity security" shall
3 mean . . . any other security which the Board shall
4 deem] to be of similar nature and consider necessary or
5 appropriate, by such rules and regulations as it may
6 prescribe in the public interest or for the protection
7 of the investors, . . . ;

8 (5) "Exempted security" or "exempted
9 securities" shall mean such securities as the Board
10 may, by such rules and regulations as it deems
11 necessary or appropriate in the public interest or for
12 the protection of investors, either conditionally or
13 upon specified terms and conditions or for stated
14 periods, exempt from the operation of any one or more
15 provisions of this Article which by their terms do not
16 apply to an "exempted security" or to "exempted
17 securities."

18 Revisor's Note

19 Section 8(5), V.T.I.C. Article 21.48, refers to
20 "terms and conditions" determined necessary or
21 appropriate by the (former) State Board of Insurance.
22 The revised law omits "conditions" as unnecessary
23 because, in this context, "conditions" is included
24 within the meaning of "terms."

25 Revisor's Note
26 (End of Subchapter)

27 (1) Section 1, V.T.I.C. Article 21.48, provides
28 a short title for that article. The revised law omits
29 the short title because Article 21.48 is not a statute
30 of wide application that is frequently referred to by
31 its short title, and the heading to this chapter of
32 the revised law is sufficient to describe the revised
33 law to the reader. The omitted law reads:

34 Art. 21.48
35 Sec. 1. This Article shall be known as
36 the "Insurance Company Insider Trading and
37 Proxy Regulation Act."

38 (2) The revised law omits as unnecessary Section
39 14, V.T.I.C. Article 21.48, which provides a
40 requirement for the effectiveness of a rule adopted
41 under Article 21.48. Chapter 2001, Government Code
42 (the administrative procedure law), prescribes the
43 procedure each agency must follow in adopting rules,

1 including the filing requirements imposed by the
2 omitted law. The omitted law reads:

3 Sec. 14. All rules and regulations
4 promulgated by the State Board of Insurance
5 under authority of this Article shall be
6 filed with the Secretary of State, and no
7 such rules or regulations shall be of any
8 force or effect until so filed.

9 [Sections 548.005-548.100 reserved for expansion]

10 SUBCHAPTER B. REQUIRED ACTS; PROHIBITIONS

11 Revised Law

12 Sec. 548.101. DEFINITION. In this subchapter, "insider"
13 means a person who:

14 (1) is directly or indirectly the beneficial owner of
15 more than 10 percent of any class of an equity security of a
16 domestic stock insurer, other than an exempt security; or

17 (2) is a director or officer of a domestic stock
18 insurer. (V.T.I.C. Art. 21.48, Secs. 2 (part), 3 (part), 4 (part).)

19 Source Law

20 Sec. 2. Every person who is directly or
21 indirectly the beneficial owner of more than ten per
22 cent of any class of any equity security (other than an
23 exempted security) of a domestic stock insurance
24 company, or who is a director or an officer of such a
25 company,

26 Sec. 3. [For the purpose of preventing the
27 unfair use of information which may have been obtained
28 by such] beneficial owner, director, or
29 officer

30 Sec. 4. [It shall be unlawful for any such]
31 beneficial owner, director, or officer,

32 Revised Law

33 Sec. 548.102. STATEMENT OF BENEFICIAL OWNERSHIP OF EQUITY
34 SECURITIES. (a) Not later than the 10th day after the date a
35 person becomes an insider, the insider shall file with the
36 department a statement of the amount of all equity securities of the
37 insurer of which the insider is a beneficial owner.

38 (b) If in any month a change occurs in the amount of the
39 equity securities of which the insider is a beneficial owner, the
40 insider shall file with the department not later than the 10th day
41 of the following month a statement that indicates:

42 (1) the amount of all equity securities of which the

1 insider is a beneficial owner as of the end of that month; and

2 (2) the changes in the insider's ownership that
3 occurred in that month.

4 (c) A statement under this section must be in the form
5 prescribed by the department. (V.T.I.C. Art. 21.48, Sec. 2
6 (part).)

7 Source Law

8 Sec. 2. Every person . . . shall file with the
9 State Board of Insurance on or before the first day of
10 July 1966 and thereafter within ten days after he
11 becomes such beneficial owner, director, or officer, a
12 statement, in such form as such Board may prescribe, of
13 the amount of all equity securities of such company of
14 which he is the beneficial owner, and within ten days
15 after the close of each calendar month thereafter, if
16 there has been a change in such ownership during such
17 month, shall file in the office of such Board a
18 statement, in such form as it may prescribe,
19 indicating his ownership at the close of the calendar
20 month and such changes in his ownership as have
21 occurred during such calendar month.

22 Revisor's Note

23 Section 2, V.T.I.C. Article 21.48, requires a
24 person described by that section to file a report with
25 the (former) State Board of Insurance under that
26 section "on or before the first day of July 1966." The
27 revised law omits the quoted language as executed.

28 Revised Law

29 Sec. 548.103. RECOVERY OF CERTAIN PROFITS. (a) The
30 purpose of this section is to prevent the unfair use of information
31 that may be obtained by an insider because of the insider's
32 relationship with the domestic stock insurer.

33 (b) Any profit realized by the insider from the purchase and
34 sale or from the sale and purchase of an equity security of the
35 domestic stock insurer within a period of less than six months
36 inures to and is recoverable by the insurer.

37 (c) A suit to recover the profit must be brought not later
38 than the second anniversary of the date the profit is realized. The
39 suit may be instituted at law or in equity by:

40 (1) the domestic stock insurer; or

1 (2) the owner of any security of the domestic stock
2 insurer, in the name of and in behalf of the insurer, if the insurer
3 does not:

4 (A) bring suit not later than the 60th day after
5 the date a request is made; or

6 (B) diligently prosecute a suit that is timely
7 brought by the insurer.

8 (d) Subsection (b) applies regardless of whether:

9 (1) the insider intended to hold the equity security
10 purchased for longer than six months; or

11 (2) the insider did not intend to repurchase the sold
12 equity security during the six-month period following the date the
13 insider sold the equity security.

14 (e) Subsection (b) does not apply to:

15 (1) a transaction in which an equity security was
16 acquired in good faith in connection with a previously contracted
17 debt;

18 (2) a transaction in which the beneficial owner of an
19 equity security was not the beneficial owner at both the time of the
20 purchase and the time of the sale, or the sale and purchase, of the
21 security involved;

22 (3) a transaction involving an exempt security;

23 (4) a transaction that the commissioner by rule
24 exempts from this section because it is beyond the scope of the
25 purpose of this section; or

26 (5) a transaction involving an equity security of a
27 domestic stock insurer that is not held by a dealer in an investment
28 account if the transaction:

29 (A) is in the ordinary course of the dealer's
30 business; and

31 (B) is incident to the establishment or
32 maintenance by the dealer of a primary or secondary market, other
33 than on an exchange, as defined by the federal Securities Exchange
34 Act, for the security.

1 (f) The commissioner may adopt rules the commissioner
2 considers necessary or appropriate in the public interest to define
3 and prescribe terms and conditions with respect to a security held
4 in an investment account and a transaction made in the ordinary
5 course of business and incident to the establishment or maintenance
6 of a primary or secondary market. (V.T.I.C. Art. 21.48, Secs. 3, 6
7 (part).)

8 Source Law

9 Sec. 3. For the purpose of preventing the unfair
10 use of information which may have been obtained by such
11 beneficial owner, director, or officer by reason of
12 his relationship to such company, any profit realized
13 by him from any purchase and sale, or any sale and
14 purchase, of any equity security of such company
15 (other than an exempted security) within any period of
16 less than six months, unless such security was
17 acquired in good faith in connection with a debt
18 previously contracted, shall inure to and be
19 recoverable by the company, irrespective of any
20 intention on the part of such beneficial owner,
21 director, or officer in entering into such transaction
22 of holding the security purchased or of not
23 repurchasing the security sold for a period exceeding
24 six months. Suit to recover such profit may be
25 instituted at law or in equity in any court of
26 competent jurisdiction by the company, or by the owner
27 of any security of the company in the name and in
28 behalf of the company if the company shall fail or
29 refuse to bring such suit within sixty days after
30 request or shall fail diligently to prosecute the same
31 thereafter; but no such suit shall be brought more than
32 two years after the date such profit was realized.
33 This Section shall not be construed to cover any
34 transaction where such beneficial owner was not such
35 both at the time of the purchase and sale, or the sale
36 and purchase, of the security involved, or any
37 transaction or transactions which the State Board of
38 Insurance by rules and regulations may exempt as not
39 comprehended within the purpose of this Section.

40 Sec. 6. The provisions of Section 3 of this
41 Article shall not apply to any purchase and sale, or
42 sale and purchase . . . of an equity security of a
43 domestic stock insurance company not then or
44 theretofore held by him in an investment account, by a
45 dealer in the ordinary course of his business and
46 incident to the establishment or maintenance by him of
47 a primary or secondary market (otherwise than on an
48 exchange as defined in the Securities Exchange Act of
49 1934) for such security. The State Board of Insurance
50 may, by such rules and regulations as it deems
51 necessary or appropriate in the public interest,
52 define and prescribe terms and conditions with respect
53 to securities held in an investment account and
54 transactions made in the ordinary course of business
55 and incident to the establishment or maintenance of a
56 primary or secondary market.

1 Revisor's Note

2 Section 3, V.T.I.C. Article 21.48, refers to a
3 suit brought "in any court of competent jurisdiction."
4 Throughout this chapter, the revised law omits the
5 quoted language as unnecessary in that context because
6 a suit may only be brought in a court, and the general
7 laws of civil jurisdiction determine which courts
8 have jurisdiction over the matter. For example, see
9 Sections 24.007-24.011, Government Code, for the
10 general jurisdiction of district courts.

11 Revised Law

12 Sec. 548.104. SALE OR NONDELIVERY OF CERTAIN EQUITY
13 SECURITIES PROHIBITED. (a) An insider may not directly or
14 indirectly sell an equity security of the domestic stock insurer if
15 the insider selling the security or the insider's principal:

16 (1) does not own the security; or

17 (2) owns the security, but does not:

18 (A) deliver the security before the 21st day
19 after the date of the sale; or

20 (B) deposit the security in the mail or another
21 usual channel of transportation before the sixth day after the date
22 of the sale.

23 (b) An insider is not considered to have violated Subsection
24 (a)(2) if the insider proves that:

25 (1) notwithstanding the exercise of good faith, the
26 insider was unable to make a timely delivery or deposit; or

27 (2) to make a timely delivery or deposit would cause
28 undue inconvenience or expense.

29 (c) Subsection (a) does not apply to the sale of:

30 (1) an exempt security; or

31 (2) an equity security of a domestic stock insurer
32 that is not held by a dealer in an investment account if the sale:

33 (A) is in the ordinary course of the dealer's
34 business; and

1 (B) is incident to the establishment or
2 maintenance by the dealer of a primary or secondary market, other
3 than on an exchange, as defined by the federal Securities Exchange
4 Act, for the security.

5 (d) The commissioner may adopt rules implementing
6 Subsection (c) in the manner prescribed by Section 548.103(f).
7 (V.T.I.C. Art. 21.48, Secs. 4, 6 (part).)

8 Source Law

9 Sec. 4. It shall be unlawful for any such
10 beneficial owner, director, or officer, directly or
11 indirectly, to sell any equity security of such
12 company (other than an exempted security) if the
13 person selling the security or his principal (i) does
14 not own the security sold, or (ii) if owning the
15 security, does not deliver it against such sale within
16 twenty days thereafter, or does not within five days
17 after such sale deposit it in the mails or other usual
18 channels of transportation; but no person shall be
19 deemed to have violated this Section if he proves that
20 notwithstanding the exercise of good faith he was
21 unable to make such delivery or deposit within such
22 time, or that to do so would cause undue inconvenience
23 or expense.

24 Sec. 6. . . . , and the provisions of Section 4
25 of this Article shall not apply to any sale, of an
26 equity security of a domestic stock insurance company
27 not then or theretofore held by him in an investment
28 account, by a dealer in the ordinary course of his
29 business and incident to the establishment or
30 maintenance by him of a primary or secondary market
31 (otherwise than on an exchange as defined in the
32 Securities Exchange Act of 1934) for such security.
33 The State Board of Insurance may[, by such rules and
34 regulations as it deems necessary or appropriate in
35 the public interest,] define and prescribe terms and
36 conditions [with respect to securities held in an
37 investment account and transactions made in the
38 ordinary course of business and incident to the
39 establishment or maintenance of a primary or secondary
40 market.]

41 Revised Law

42 Sec. 548.105. CERTAIN SOLICITATIONS PROHIBITED; DISCLOSURE
43 BY INSURER. (a) A person, in violation of any rule adopted by the
44 commissioner under this section, may not solicit or permit the use
45 of the person's name to solicit a proxy, consent, or authorization
46 with respect to an equity security, other than an exempt security,
47 of a domestic stock insurer that is not listed on a national
48 securities exchange registered as such under the federal Securities
49 Exchange Act.

1 (b) Unless before an annual or other meeting a proxy,
2 consent, or authorization with respect to a security of a domestic
3 stock insurer covered by Subsection (a) is solicited by or on behalf
4 of the management of the insurer from a holder of record of the
5 security in compliance with rules adopted by the commissioner under
6 this section, the insurer shall, in accordance with rules adopted
7 by the commissioner, file with the department information
8 substantially equivalent to the information that would be required
9 to be sent if a solicitation were made. The insurer shall send the
10 information to each holder of record of the security.

11 (c) The commissioner may adopt rules to implement this
12 section that the commissioner considers necessary or appropriate in
13 the public interest or for the protection of investors. (V.T.I.C.
14 Art. 21.48, Sec. 5.)

15 Source Law

16 Sec. 5. (1) It shall be unlawful for any person,
17 in contravention of such rules and regulations as the
18 State Board of Insurance may prescribe as necessary or
19 appropriate in the public interest or for the
20 protection of investors, to solicit or to permit the
21 use of his name to solicit any proxy or consent or
22 authorization in respect of any equity security (other
23 than an exempted security) of a domestic stock
24 insurance company not listed on a national securities
25 exchange registered as such under the United States
26 Securities Exchange Act of 1934, as amended.

27 (2) Unless proxies, consents, or
28 authorizations in respect of a security of a domestic
29 stock insurance company subject to subsection (1) of
30 this Section 5 are solicited by or on behalf of the
31 management of such company from the holders of record
32 of stock of such company in accordance with the rules
33 and regulations prescribed under this Section 5 prior
34 to any annual or other meeting, such company shall, in
35 accordance with such rules and regulations prescribed
36 by the Board, file with the Commissioner and transmit
37 to all holders of record of such security, information
38 substantially equivalent to the information which
39 would be required to be transmitted if a solicitation
40 were made.

41 Revised Law

42 Sec. 548.106. NONAPPLICABILITY OF SUBCHAPTER. (a) This
43 subchapter does not apply to an equity security of a domestic stock
44 insurer if:

45 (1) the security is or is required to be registered
46 under Section 12 of the federal Securities Exchange Act; or

1 (2) the insurer does not have any class of its equity
2 securities held of record by 100 or more persons on the last
3 business day of the year preceding the year in which the equity
4 security would otherwise be subject to this subchapter.

5 (b) Sections 548.101-548.104 do not apply to a foreign or
6 domestic arbitrage transaction unless the transaction is made in
7 violation of a rule adopted by the commissioner to accomplish the
8 purposes of this chapter.

9 (c) A provision of this subchapter that imposes liability
10 does not apply to an act or omission made in good faith in
11 conformity with a rule adopted by the commissioner. This
12 subsection applies regardless of whether the rule is subsequently
13 amended, rescinded, or determined by judicial or other authority to
14 be invalid for any reason. (V.T.I.C. Art. 21.48, Secs. 7, 9, 10
15 (part).)

16 Source Law

17 Sec. 7. The provisions of Sections 2, 3 and 4 of
18 this Article shall not apply to foreign or domestic
19 arbitrage transactions unless made in contravention of
20 such rules and regulations as the State Board of
21 Insurance may adopt in order to carry out the purposes
22 of this Act.

23 Sec. 9. The provisions of Sections 2, 3, 4 and 5
24 of this Article shall not apply to equity securities of
25 a domestic stock insurance company if (a) such
26 securities shall be registered, or shall be required
27 to be registered, pursuant to Section 12 of the
28 Securities Exchange Act of 1934, as amended, or if (b)
29 such domestic stock insurance company shall not have
30 any class of its equity securities held of record by
31 one hundred or more persons on the last business day of
32 the year next preceding the year in which equity
33 securities of the company would be subject to the
34 provisions of Sections 2, 3, 4, and 5 of this Article
35 except for the provisions of this subsection (b).

36 Sec. 10. . . . No provision of Sections 2, 3,
37 4, and 5 of this Article imposing any liability shall
38 apply to any act done or omitted in good faith in
39 conformity with any rule or regulation of the said
40 Board, notwithstanding that such rule or regulation
41 may, after such act or omission, be amended or
42 rescinded or determined by judicial or other authority
43 to be invalid for any reason.

44 Revisor's Note

45 Section 9, V.T.I.C. Article 21.48, refers to the
46 year "next preceding" a certain year. The revised law

1 omits "next" as unnecessary. "The preceding" means
2 "the next preceding."

3 [Sections 548.107-548.200 reserved for expansion]

4 SUBCHAPTER C. ENFORCEMENT

5 Revised Law

6 Sec. 548.201. OFFENSES; CRIMINAL PENALTY. (a) A person
7 commits an offense if the person intentionally:

8 (1) violates this chapter or a rule adopted under this
9 chapter; or

10 (2) makes or causes to be made a statement that is
11 false or misleading with respect to a material fact in a document
12 required to be filed by this chapter or a rule adopted under this
13 chapter.

14 (b) Except as provided by Subsection (c), an offense under
15 this section is punishable by:

16 (1) a fine not to exceed \$10,000;

17 (2) imprisonment for not more than two years; or

18 (3) both the fine and imprisonment.

19 (c) A person may not be punished by imprisonment for
20 violating a rule as prescribed by this section if the person proves
21 that the person had no knowledge of the rule. (V.T.I.C. Art. 21.48,
22 Sec. 11.)

23 Source Law

24 Sec. 11. Any person who wilfully violates any
25 provision of this Article or any rule or regulation
26 thereunder the violation of which is made unlawful or
27 the observance of which is required under the terms of
28 this Article, or any person who wilfully and knowingly
29 makes, or causes to be made, any statement in any
30 document required to be filed under this Article or any
31 rule or regulation thereunder which statement was
32 false or misleading with respect to any material fact,
33 shall upon conviction be fined not more than ten
34 thousand dollars, or imprisoned not more than two
35 years, or both; but no person shall be subject to
36 imprisonment under this Section 11 for the violation
37 of any rule or regulation if he proves that he has no
38 knowledge of such rule or regulation.

39 Revisor's Note

40 Section 11, V.T.I.C. Article 21.48, refers to a
41 person who "wilfully" violates a provision of that

1 article or certain rules or who "wilfully and
2 knowingly" makes or causes to be made certain false or
3 misleading statements. The revised law substitutes
4 "intentionally" for "wilfully" because the terms are
5 synonymous and "intentional" is the term prescribed by
6 Section 6.02, Penal Code, which classifies culpable
7 mental states in criminal offenses. The revised law
8 omits "knowingly" because under Section 6.02, Penal
9 Code, an "intentional" mental state includes a
10 "knowing" mental state.

11 Revised Law

12 Sec. 548.202. CIVIL PENALTY. (a) A person who wilfully
13 violates this chapter or a rule adopted under this chapter is liable
14 for a civil penalty of not less than \$100 or more than \$1,000 for:

15 (1) each act of violation; and

16 (2) each day of violation.

17 (b) The attorney general, at the request of the
18 commissioner, shall bring a suit in the name of the state to recover
19 the civil penalty. The suit must be brought:

20 (1) in Travis County or the county in which the person
21 resides;

22 (2) if more than one person commits the violation, in
23 the county in which any of the persons resides; or

24 (3) in the county in which the violation allegedly
25 occurred. (V.T.I.C. Art. 21.48, Sec. 12 (part).)

26 Source Law

27 Sec. 12. Any person wilfully violating any of
28 the provisions of this Article or wilfully violating
29 any rule or regulation of the Board promulgated
30 hereunder, shall be subject to a civil penalty of not
31 less than one hundred dollars nor more than one
32 thousand dollars for each and every day of such
33 violation, and for each and every act of such
34 violation, to be recovered in any court of competent
35 jurisdiction in Travis County, or in the county of the
36 residence of the defendant or, if there be more than
37 one defendant, in the county of the residence of any of
38 them, or in the county in which the violation is
39 alleged to have occurred, such suit to be instituted at
40 the direction of the Board and conducted in the name of
41 the State of Texas by the Attorney General. . . .

1 Revisor's Note

2 The revised law omits as unnecessary the part of
3 Section 12, V.T.I.C. Article 21.48, relating to the
4 cumulative effect of the remedy provided by that
5 section. An accepted general principle of statutory
6 construction requires a statute to be given cumulative
7 effect with other statutes unless it provides
8 otherwise or unless the statutes are in conflict. The
9 general principle applies to this revision. The
10 omitted law reads:

11 Sec. 12. . . . This penalty shall
12 be in addition to any forfeiture or penalty
13 that may be provided for by law. . . .

14 Revised Law

15 Sec. 548.203. INJUNCTIVE ACTION. A suit to enjoin a
16 violation or a threatened violation of this chapter may be brought
17 in any district court in which an action for a civil penalty under
18 Section 548.202 may be brought. (V.T.I.C. Art. 21.48, Sec. 12
19 (part).)

20 Source Law

21 Sec. 12. . . . Any and all violations, and
22 threatened violations, of this Article may be enjoined
23 by any court of competent jurisdiction in which suit
24 for penalty may be brought, and in such cases the court
25 shall issue such writs or injunctions, prohibitory or
26 mandatory, as the facts justify.

27 Revisor's Note

28 Section 12, V.T.I.C. Article 21.48, states that
29 certain violations may be enjoined by any court of
30 competent jurisdiction in which a suit to recover the
31 civil penalty provided by that section may be brought
32 and that "the court shall issue such writs or
33 injunctions, prohibitory or mandatory, as the facts
34 justify." The revised law substitutes a reference to a
35 district court for the reference to a court of
36 competent jurisdiction because the district court is
37 the only trial court with original jurisdiction to

1 issue a writ or injunction. See Sections
 2 24.007-24.011, Government Code. The revised law omits
 3 the quoted language as unnecessary because it does not
 4 add to a court's duty or authority to grant appropriate
 5 relief according to the facts of the case before the
 6 court.

7 CHAPTER 549. PROHIBITED PRACTICES RELATING TO
 8 PROPERTY INSURANCE

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16 SUBCHAPTER B. PROHIBITED PRACTICES

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25 [Sections 549.057-549.100 reserved for expansion]

26 SUBCHAPTER C. ENFORCEMENT AND CIVIL REMEDIES

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29 CHAPTER 549. PROHIBITED PRACTICES RELATING TO PROPERTY INSURANCE

30 SUBCHAPTER A. GENERAL PROVISIONS

31 Revised Law

32 Sec. 549.001. DEFINITIONS. In this chapter:

33 (1) "Borrower" means an individual, partnership,
 34 corporation, association, or other entity who has or acquires a

1 legal or equitable interest in real or personal property that is or
2 becomes subject to a mortgage, lien, security agreement, deed of
3 trust, or other security instrument.

4 (2) "Insurance binder" means a contract that provides
5 insurance coverage pending the issuance of an original insurance
6 policy that will be issued on or before the 30th day after the date
7 the insurance binder is issued.

8 (3) "Lender" means an individual, partnership,
9 corporation, association, or other entity, agent, loan agent,
10 servicing agent, or loan or mortgage broker who lends money and
11 receives or otherwise acquires a mortgage, a lien, a deed of trust,
12 or any other security interest in or on any real or personal
13 property as security for the loan. (V.T.I.C. Art. 21.48A, Sec. 1.)

14 Source Law

15 Art. 21.48A

16 Sec. 1. (1) "Lender" means any person,
17 partnership, corporation, association, or other
18 entity, or any agent, loan agent, servicing agent, or
19 any loan or mortgage broker, who lends money and
20 receives or otherwise acquires a mortgage, lien, deed
21 of trust, or any other security interest in or upon any
22 real or personal property as security for such loan.

23 (2) "Borrower" means any person,
24 partnership, corporation, association, or other
25 entity, who has or acquires a legal or equitable
26 interest in real or personal property which is or
27 becomes subject to a mortgage, lien, security
28 agreement, deed of trust, or other security
29 instrument.

30 (3) "Insurance binder" means a contract
31 that provides insurance coverage pending the issuance
32 of an original insurance policy which will be issued
33 within 30 days of the issuance of the insurance binder.

34 Revised Law

35 Sec. 549.002. INAPPLICABILITY OF CHAPTER TO TITLE
36 INSURANCE. This chapter does not apply to title insurance.
37 (V.T.I.C. Art. 21.48A, Sec. 5.)

38 Source Law

39 Sec. 5. Nothing contained herein shall apply to
40 title insurance.

41 Revised Law

42 Sec. 549.003. CANCELLATION OF POLICY AFTER FORECLOSURE
43 AUTHORIZED. In the event of a foreclosure under a deed of trust,

1 the lender may cancel an insurance policy covering the foreclosed
2 property and is entitled to any unearned premiums from the policy if
3 the lender:

4 (1) credits the amount of the unearned premiums
5 against any deficiency owed by the borrower; and

6 (2) delivers to the borrower any excess unearned
7 premiums not credited against a deficiency under Subdivision (1).

8 (V.T.I.C. Art. 21.48A, Sec. 3A.)

9 Source Law

10 Sec. 3A. In the event of a foreclosure under a
11 deed of trust, the lender may cancel any policy of
12 insurance covering the property foreclosed upon and
13 shall be entitled to any unearned premiums from that
14 policy, provided the lender credits the amount of such
15 unearned premiums against any deficiency owed by the
16 borrower and delivers any excess unearned premiums not
17 so credited to the borrower.

18 [Sections 549.004-549.050 reserved for expansion]

19 SUBCHAPTER B. PROHIBITED PRACTICES

20 Revised Law

21 Sec. 549.051. FEES FOR SUBSTITUTION OR REPLACEMENT OF
22 POLICY. (a) A lender may not require a fee in an amount greater
23 than \$10 for the substitution by the borrower of a new insurance
24 policy for another insurance policy in effect, or require a fee for
25 the furnishing by the borrower of a new insurance policy to replace
26 an existing insurance policy on termination of the existing policy,
27 if the new insurance policy is provided through an insurer
28 authorized to engage in business in this state.

29 (b) On the sale or transfer of the lender's ownership
30 interest in real or personal property, the lender is subject to the
31 payment of a substitution fee as described by Subsection (a) and may
32 not, directly or indirectly, charge the borrower for the
33 substitution fee. (V.T.I.C. Art. 21.48A, Secs. 2(a), (e).)

34 Source Law

35 Sec. 2. (a) No Lender shall require a fee of
36 over Ten Dollars (\$10.00) for the substitution by the
37 Borrower of an insurance policy for another insurance
38 policy still in effect, or require any fee for the
39 furnishing by the Borrower of an insurance policy for
40 an existing policy upon termination of the existing

1 policy, when such insurance policy is provided through
2 an insurance company duly licensed to do business in
3 the State of Texas pursuant to the provisions of this
4 Insurance Code.

5 (e) Upon the sale or transfer of its ownership
6 interest in real or personal property, a lender is
7 subject to the payment of a substitution fee as
8 described in Section 2(a) of this article and the
9 lender may not, directly or indirectly, charge the
10 borrower for such substitution fee.

11 Revisor's Note

12 Section 2(a), V.T.I.C. Article 21.48A, refers to
13 an insurer "duly licensed to do business" in this
14 state. The revised law substitutes "authorized" for
15 "duly licensed" for consistency of terminology because
16 "certificate of authority" is the term used throughout
17 this code in relation to an entity's authority to
18 engage in the business of insurance. Similar changes
19 have been made throughout this chapter.

20 Revised Law

21 Sec. 549.052. REQUIRING POLICY FROM PARTICULAR SOURCE. A
22 lender may not directly or indirectly require as a condition of the
23 financing or lending of money or the renewal or extension of
24 financing or lending of money that the purchaser or borrower or the
25 successors of the purchaser or borrower obtain an insurance policy
26 or the renewal or extension of an insurance policy covering the
27 property involved in the transaction from or through:

- 28 (1) a particular agent, insurer, or other person; or
29 (2) a particular type or class of agent, insurer, or
30 other person. (V.T.I.C. Art. 21.48A, Sec. 2(b).)

31 Source Law

32 (b) No Lender shall directly or indirectly
33 impose or require as a condition of any financing or
34 lending of money or the renewal or the extension
35 thereof, that the purchaser or borrower or his
36 successors, shall procure any policy of insurance or
37 the renewal or extension thereof, covering the
38 property involved in the transaction, from or through
39 any particular agent or agents, solicitor or
40 solicitors, insurer or insurers, or any other person
41 or persons, or from or through any particular type or
42 class of any of the foregoing.

1 Revisor's Note

2 (1) Section 2(b), V.T.I.C. Article 21.48A,
3 states that a lender may not "impose or require as a
4 condition" that insurance be purchased from certain
5 persons. The revised law omits "impose" as
6 unnecessary because requiring something as a condition
7 is equivalent to imposing the condition.

8 (2) Section 2(b), V.T.I.C. Article 21.48A,
9 refers to a "solicitor or solicitors." The revised law
10 omits the reference to "solicitor" because that term,
11 as it relates to a particular type of person engaged in
12 the business of insurance, was eliminated by Chapter
13 703, Acts of the 77th Legislature, Regular Session,
14 2001, and a person who performs the duties formerly
15 performed by a solicitor is now regulated as an
16 "agent."

17 Revised Law

18 Sec. 549.053. USE OF POLICY INFORMATION. (a) Except as
19 otherwise provided by this section, a lender may not:

20 (1) use or permit the use of any information taken from
21 an insurance policy insuring the borrower's property for the
22 purpose of soliciting insurance business from the borrower; or

23 (2) make information taken from an insurance policy
24 insuring the borrower's property available to any other person for
25 any purpose.

26 (b) Subsection (a) does not:

27 (1) apply if the borrower provides the lender with
28 specific written authority permitting or directing the particular
29 use or disclosure of information before the use or disclosure
30 occurs; or

31 (2) prevent a lender who is a licensed general
32 property and casualty agent from selling insurance to a borrower.

33 (V.T.I.C. Art. 21.48A, Sec. 2(c).)

1 Source Law

2 (c) No Lender shall use or permit the use of any
3 of the information taken from a policy of insurance
4 insuring the property of a Borrower for the purpose of
5 soliciting insurance business from the Borrower, or
6 make any of such information available to any other
7 person for any purpose, unless such Lender has first
8 been furnished specific written authority from the
9 Borrower permitting or directing such particular use
10 or disclosure; provided, however, this paragraph shall
11 not prevent a Lender who is a licensed local recording
12 agent from selling insurance to a Borrower.

13 Revisor's Note

14 Section 2(c), V.T.I.C. Article 21.48A, refers to
15 a person who is licensed as a "local recording agent."
16 Chapter 703, Acts of the 77th Legislature, Regular
17 Session, 2001, consolidated the types of licenses
18 issued to insurance agents and eliminated the license
19 category of "local recording agent." V.T.I.C. Article
20 21.14, as amended by Article 3, Chapter 703, Acts of
21 the 77th Legislature, Regular Session, 2001, replaced
22 the category of "local recording agent" with a new
23 licensing category, that of "general property and
24 casualty agent." Throughout this chapter, the revised
25 law is drafted accordingly.

26 Revised Law

27 Sec. 549.054. REQUIRING EVIDENCE OF INSURANCE BEFORE
28 TERMINATION OF POLICY. A lender may not require a borrower to
29 provide evidence of insurance earlier than the 15th day before the
30 termination date of an existing insurance policy. (V.T.I.C. Art.
31 21.48A, Sec. 2(d).)

32 Source Law

33 (d) No Lender may require a Borrower to furnish
34 evidence of insurance more than fifteen (15) days
35 prior to the termination date of an existing policy.

36 Revised Law

37 Sec. 549.055. INSURANCE BINDER AS EVIDENCE OF
38 INSURANCE. (a) A lender that requires a borrower to secure
39 insurance coverage before the lender will provide a residential
40 mortgage or commercial real estate loan must accept an insurance

1 binder as evidence of the required insurance and may not require the
2 borrower to provide an original insurance policy instead of a
3 binder if:

4 (1) the binder is issued by a licensed general
5 property and casualty agent who is appointed to represent the
6 insurer whose name appears on the binder and who is authorized to
7 issue binders;

8 (2) the binder is accompanied by evidence of payment
9 of the required premium; and

10 (3) the binder will be replaced by an original
11 insurance policy for the required coverage on or before the 30th day
12 after the date the binder is issued.

13 (b) A general property and casualty agent who issues an
14 insurance binder under Subsection (a) must, on request, provide the
15 lender with appropriate evidence for purposes of Subsection (a)(1).
16 (V.T.I.C. Art. 21.48A, Sec. 2(f).)

17 Source Law

18 (f) A Lender that requires a Borrower to secure
19 insurance coverage before the Lender will provide a
20 residential mortgage or commercial real estate loan
21 shall accept an insurance binder as evidence of the
22 required insurance if:

23 (1) the insurance binder is issued by a
24 licensed local recording agent as that term is defined
25 by Article 21.14 of this code and, if requested to do
26 so, the agent shall furnish appropriate evidence to
27 the Lender;

28 (2) the local recording agent is appointed
29 to represent the insurance company whose name appears
30 on the binder and is authorized to issue binders and,
31 if requested to do so, the agent shall furnish
32 appropriate evidence to the Lender;

33 (3) the insurance binder is accompanied by
34 evidence of payment of the required premium; and

35 (4) the insurance binder will be replaced
36 by an original insurance policy for the required
37 coverage within 30 days of the date of the issuance of
38 the insurance binder.

39 If the foregoing conditions are met, a Lender may
40 not require a Borrower to provide an original
41 insurance policy in lieu of the insurance binder.

42 Revised Law

43 Sec. 549.056. CERTAIN ACTIONS BY LENDER NOT
44 PROHIBITED. (a) This subchapter does not prevent a lender from
45 requiring evidence to be produced before the commencement or

1 renewal of a risk that insurance has been obtained that:

2 (1) has a fixed termination date;

3 (2) provides adequate coverage in an amount sufficient
4 to cover the debt or loan; and

5 (3) will not be canceled without reasonable notice to
6 the lender.

7 (b) This subchapter does not prevent a lender from requiring
8 insurance from an insurer that is authorized to engage in business
9 in this state and that has a licensed resident agent in this state.

10 (c) This subchapter does not prevent a lender from refusing
11 to accept or approve insurance from a particular insurer on
12 reasonable and nondiscriminatory grounds relating to the financial
13 soundness of the insurer or the insurer's ability to service the
14 policy.

15 (d) This subchapter does not prevent a lender from
16 providing, in accordance with the terms of the mortgage, security
17 agreement, deed of trust, or other security instrument, insurance
18 coverage adequate to protect the lender's security interest in
19 property in the event the borrower fails to provide on or before the
20 15th day before the termination date of an existing insurance
21 policy an insurance policy meeting the requirements established by
22 the lender as authorized by this chapter. A lender that provides
23 insurance coverage under this subsection may use information
24 contained in the existing policy for the purpose of determining
25 that the insurance coverage provided is adequate.

26 (e) Except as provided by this subsection, this subchapter
27 does not prevent a lender from requiring at or before the time of
28 delivery by a general property and casualty agent or insurer of an
29 insurance policy to the lender a written statement from the
30 borrower designating the agent or insurer as the borrower's agent
31 for the delivery of the policy. A lender may not require a
32 statement described by this subsection when an agent or insurer is
33 providing a renewal of an existing expiring insurance policy
34 provided by the agent or insurer.

1 (f) This subchapter does not prevent a lender from providing
2 to a person, firm, or corporation that is or becomes the owner or
3 holder of a note or obligation secured by a mortgage, security
4 agreement, deed of trust, or other security instrument an insurance
5 policy or any information contained in an insurance policy that
6 covers property that is security for the loan.

7 (g) This subchapter does not prevent a lender from
8 processing a claim under the terms of an insurance policy that
9 covers property that is security for a loan. (V.T.I.C. Art. 21.48A,
10 Sec. 3.)

11 Source Law

12 Sec. 3. Nothing contained in Section 2 hereof
13 shall be deemed to prevent such Lender from:

14 (a) requiring evidence, to be produced
15 prior to the commencement or renewal of the risk, that
16 insurance with a fixed termination date providing
17 adequate coverage has been obtained in an amount
18 sufficient to cover the debt or loan and that it will
19 not be cancelled without reasonable notice to the
20 lender;

21 (b) requiring insurance in an insurer
22 authorized to do business and having a licensed
23 resident agent in this state;

24 (c) refusing to accept or approve
25 insurance in any particular insurer on reasonable and
26 nondiscriminatory grounds relating to its financial
27 soundness, or its facility to service the policy;

28 (d) providing adequate insurance coverage
29 to protect the Lender's security interest in any
30 property in accordance with the terms of the mortgage,
31 security agreement, deed of trust, or other security
32 instrument should the Borrower fail to furnish an
33 insurance policy meeting the requirements established
34 by the Lender as authorized by this article within
35 fifteen (15) days prior to the termination date of an
36 existing policy, and in such instance the Lender shall
37 be entitled to use any information contained in the
38 existing policy for the purpose of determining
39 adequate insurance coverage;

40 (e) requiring at or before the time of
41 delivery of an insurance policy to the Lender by a
42 local recording agent or insurer a statement in
43 writing from the Borrower designating such agent or
44 insurer as his agent for such purpose; provided,
45 however, such statement shall not be required when an
46 agent or insurer is furnishing a renewal of an existing
47 expiring policy provided by such agent or insurer;

48 (f) furnishing to any person, firm, or
49 corporation who is or becomes the owner or holder of
50 any note or obligation secured by a mortgage, security
51 agreement, deed of trust, or other security instrument
52 the policy of insurance or any information contained
53 therein covering property which is security for such
54 loan; or

55 (g) processing a claim under the terms of
56 the insurance policy.

1 [Sections 549.057-549.100 reserved for expansion]

2 SUBCHAPTER C. ENFORCEMENT AND CIVIL REMEDIES

3 Revised Law

4 Sec. 549.101. ENFORCEMENT ACTION. The attorney general,
5 commissioner, or department may institute a proceeding to enforce
6 this chapter and to enjoin any individual, partnership,
7 corporation, association, or other entity from engaging or
8 attempting to engage in any activity in violation of this chapter.
9 (V.T.I.C. Art. 21.48A, Sec. 4(a) (part).)

10 Source Law

11 Sec. 4. (a) The attorney general or the
12 commissioner or board may institute any injunction or
13 other proceeding to enforce the provisions of this
14 article and to enjoin any person, partnership,
15 corporation, association, or other entity from
16 engaging or attempting to engage in any activity in
17 violation of this article or any of its
18 provisions. . . .

19 Revisor's Note

20 (1) Section 4(a), V.T.I.C. Article 21.48A,
21 refers to the institution of a proceeding by the
22 attorney general, the commissioner, or the "board,"
23 meaning the State Board of Insurance. Chapter 685,
24 Acts of the 73rd Legislature, Regular Session, 1993,
25 abolished the board and transferred its functions to
26 the commissioner of insurance and the Texas Department
27 of Insurance. The revised law accordingly refers to
28 the department instead of the board.

29 (2) Section 4(a), V.T.I.C. Article 21.48A,
30 provides that the section is cumulative of other
31 penalties or remedies provided by law. The revised law
32 omits that provision as unnecessary because an
33 accepted general principle of statutory construction
34 requires a statute to be given cumulative effect with
35 other statutes unless the statute provides otherwise
36 or the statutes are in conflict. That general
37 principle applies to the revised law. The omitted law

1 reads:

2 (a) . . . The provisions of this
3 section are cumulative of the other
4 penalties or remedies provided for by law.

5 Revised Law

6 Sec. 549.102. CIVIL DAMAGES. (a) A borrower may recover
7 from a lender who violates this chapter civil damages in an amount
8 equal to three times the annual premium for the insurance policy in
9 force on the property that is security for the loan.

10 (b) If the insurance policy is for a period of more than one
11 year, the annual premium is computed by dividing the total premium
12 specified in the policy for the entire period of the policy by the
13 number of years of the duration of the policy. (V.T.I.C. Art.
14 21.48A, Sec. 4(b).)

15 Source Law

16 (b) A Borrower may recover from any Lender who
17 violates any of the provisions of this article civil
18 damages in an amount equal to three (3) times the
19 annual premium for the policy of insurance in force
20 upon the mortgaged property. In the event that such
21 policy of insurance be for a period of more than one
22 (1) year, the annual premium shall be calculated by
23 dividing the number of years of the duration of such
24 policy into the total premium specified therein for
25 such entire period.

26 Revisor's Note

27 Section 4(b), V.T.I.C. Article 21.48A, refers to
28 an insurance policy on "mortgaged property." The
29 revised law substitutes "property that is security for
30 the loan" for consistency with the other provisions of
31 this chapter, including the definition of "borrower,"
32 which refers to "property . . . subject to a mortgage,
33 lien, security agreement, deed of trust, or other
34 security instrument," and the definition of "lender,"
35 which refers to a "mortgage, a lien, a deed of trust,
36 or any other security interest" in or on property as
37 "security for [a] loan."

38 CHAPTER 550. PROHIBITED PRACTICES RELATING TO PAYMENTS

39 Sec. 550.001. SOLICITATION OR COLLECTION OF CERTAIN

1 PAYMENTS 394

2 Sec. 550.002. INCREASE IN CERTAIN PREMIUM PAYMENTS 395

3 CHAPTER 550. PROHIBITED PRACTICES RELATING TO PAYMENTS

4 Revised Law

5 Sec. 550.001. SOLICITATION OR COLLECTION OF CERTAIN
6 PAYMENTS. (a) An insurer or an insurer's agent or sponsoring
7 organization may not solicit or collect, in connection with an
8 application for insurance or the issuance of a policy, a payment
9 other than:

- 10 (1) a premium;
- 11 (2) a tax;
- 12 (3) a finance charge;
- 13 (4) a policy fee;
- 14 (5) an agent fee;
- 15 (6) a service fee, including a charge for costs
16 described by Section 4005.003;
- 17 (7) an inspection fee; or
- 18 (8) membership dues in a sponsoring organization.

19 (b) The commissioner by rule shall permit a sponsoring
20 organization to solicit a voluntary contribution with a membership
21 renewal solicitation if the membership renewal solicitation is
22 separate from an insurance billing.

23 (c) Except as otherwise provided by statute, an insurer may
24 require that membership dues in its sponsoring organization be paid
25 as a condition for issuance or renewal of an insurance policy.

26 (d) Criminal penalties for a violation of this section are
27 the same as criminal penalties provided for a violation under
28 Subchapter K, Chapter 823. (V.T.I.C. Art. 21.35B.)

29 Source Law

30 Art. 21.35B. (a) No payment may be solicited or
31 collected by an insurer, its agent, or sponsoring
32 organization in connection with an application for
33 insurance or the issuance of a policy other than:

- 34 (1) premiums;
- 35 (2) taxes;
- 36 (3) finance charges;
- 37 (4) policy fees;
- 38 (5) agent fees;

1 (6) service fees, including charges for
2 costs described under Article 21.35A of this code;

3 (7) inspection fees; or

4 (8) membership dues in a sponsoring
5 organization.

6 (b) The commissioner by rule shall permit
7 sponsoring organizations to solicit voluntary
8 contributions with a membership renewal solicitation
9 when the membership renewal solicitation is separate
10 from an insurance billing.

11 (c) Except as otherwise provided by statute, an
12 insurer may require that membership dues in its
13 sponsoring organization be paid as a condition for
14 issuance or renewal of an insurance policy.

15 (d) Criminal penalties for violation of this
16 article are as provided for under Section 13, Article
17 21.49-1 of this code.

18 Revised Law

19 Sec. 550.002. INCREASE IN CERTAIN PREMIUM PAYMENTS. (a)

20 In this section:

21 (1) "Account" means a person's account in a financial
22 institution.

23 (2) "Financial institution" means a state or national
24 bank, a state or federal savings and loan association or
25 corporation, or a state or federal credit union.

26 (3) "Insurer" means a person or entity engaged in the
27 business of insurance in this state as described by Chapter 101.
28 The term includes a person or entity engaged in the business of
29 surplus lines insurance in this state.

30 (4) "Person" means an insured, a policy or certificate
31 holder, or an owner of an insurance policy or certificate.

32 (b) An insurer receiving automatic premium payments through
33 withdrawal of funds from a person's account, including an escrow
34 account, as authorized by that person to pay premiums on insurance
35 coverage provided through that insurer, may not increase the amount
36 of funds to be withdrawn from the account to pay premiums on that
37 coverage unless:

38 (1) the insurer, not later than the 30th day before the
39 effective date of the increase in the premium payment amount,
40 notifies the person of the increase and provides the person a
41 postage prepaid form that may be used to object to the increase; and

42 (2) neither the insurer nor the financial institution

1 receives written objection to the increase on or before the fifth
2 day before the date on which the increase takes effect.

3 (c) This section does not require an insurer to notify a
4 person of an increase in a premium payment amount if:

5 (1) the insurance contract or certificate:

6 (A) when issued contains a schedule of increasing
7 premiums;

8 (B) expressly specifies the exact amount of each
9 premium; and

10 (C) specifies the period for which each premium
11 is payable; or

12 (2) the increase is the result of a change ordered by
13 the insured.

14 (d) This section does not apply to an increase in a premium
15 payment that is less than \$10 or 10 percent of the previous amount
16 per month. (V.T.I.C. Art. 21.57.)

17 Source Law

18 Art. 21.57. (a) Definitions. In this article:

19 (1) "Account" means a person's account in a
20 financial institution.

21 (2) "Financial institution" means a state
22 or national bank, a state or federal savings and loan
23 association or corporation, or a state or federal
24 credit union.

25 (3) "Insurer" means any person or entity
26 transacting the business of insurance in this state,
27 as defined in Article 1.14-1 of this code, including
28 surplus lines insurance.

29 (4) "Person" means any policyholder,
30 certificateholder, insured, owner of an insurance
31 policy, or owner of a certificate.

32 (b) Any insurer receiving automatic premium
33 payments through withdrawal of funds from a person's
34 account, including the withdrawal of funds from a
35 person's escrow account, as authorized by such person
36 for purposes of premium payments on any insurance
37 coverage provided through such insurer, shall not
38 increase those premium payments to be withdrawn from
39 such an account for paying premiums on such insurance
40 coverage unless:

41 (1) the insurer, not later than the 30th
42 day before the effective date of the increase in
43 premium, notifies the person of the increase and
44 provides such person a postage prepaid form that may be
45 used to object to such increase; and

46 (2) neither the insurer nor the financial
47 institution receives written objection to the increase
48 in premium at least five days before the date on which
49 such increase takes effect.

50 (c) This article does not require an insurer to

1 notify the person of an increase in the amount of
 2 premium payment if:
 3 (1) the insurance contract or certificate
 4 contains a schedule of increasing premiums when
 5 issued, expressly specifies the exact amount of each
 6 premium, and specifies the period for which each such
 7 premium is payable; or
 8 (2) the increase is the result of a change
 9 ordered by the insured.
 10 (e) This article does not apply to an increase
 11 in premium payment that is less than \$10 or ten percent
 12 of the previous amount per month.

13 CHAPTER 551. PROHIBITED PRACTICES RELATING TO DECLINATION,
 14 CANCELLATION, AND NONRENEWAL OF INSURANCE POLICIES

15 SUBCHAPTER A. GENERAL REQUIREMENTS

16 Sec. 551.001. RULES 398
 17 Sec. 551.002. WRITTEN STATEMENT OF REASONS FOR DECLINATION,
 18 CANCELLATION, OR NONRENEWAL 400
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20 [Sections 551.004-551.050 reserved for expansion]

21 SUBCHAPTER B. CANCELLATION AND NONRENEWAL OF CERTAIN LIABILITY
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30 [Sections 551.057-551.100 reserved for expansion]

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8 [Sections 551.113-551.150 reserved for expansion]

9 SUBCHAPTER D. CANCELLATION OR NONRENEWAL OF CERTAIN POLICIES

10 ISSUED TO ELECTED OFFICIALS

11 Sec. 551.151. DEFINITION. 415
12 Sec. 551.152. ELECTED OFFICIALS. 415

13 CHAPTER 551. PROHIBITED PRACTICES RELATING TO DECLINATION,
14 CANCELLATION, AND NONRENEWAL OF INSURANCE POLICIES

15 SUBCHAPTER A. GENERAL REQUIREMENTS

16 Revised Law

17 Sec. 551.001. RULES. (a) The commissioner may, as
18 necessary, adopt and enforce reasonable rules, including notice
19 requirements, relating to the cancellation and nonrenewal of any
20 insurance policy regulated by the department under Chapter 5, other
21 than:

- 22 (1) a policy subject to Subchapter B or C; or
- 23 (2) a marine insurance policy other than inland
24 marine.

25 (b) In adopting rules under this section, the commissioner
26 shall consider the reasonable needs of the public and the
27 operations of the insurers. (V.T.I.C. Art. 21.49-2 (part).)

28 Source Law

29 Art. 21.49-2. The State Board of Insurance is
30 authorized, as it finds necessary, to prescribe,
31 adopt, promulgate, and enforce reasonable rules and
32 regulations as to the cancellation and the nonrenewal
33 of all policies of insurance, other than policies
34 subject to Section 21.49-2A or 21.49-2B of this code or
35 marine insurance policies other than inland marine,
36 regulated by the Board pursuant to Chapter 5, Texas
37 Insurance Code, including notice requirements
38 thereof, applicable to all of those policies. . . . In
39 prescribing and adopting such rules and regulations,

1 the Board will give consideration to the reasonable
2 needs of the public and to the operations of the
3 insurance companies. . . .

4 Revisor's Note

5 (1) V.T.I.C. Article 21.49-2 refers to the State
6 Board of Insurance. Chapter 685, Acts of the 73rd
7 Legislature, Regular Session, 1993, abolished the
8 board and transferred its functions to the
9 commissioner of insurance and the Texas Department of
10 Insurance. Throughout this chapter, references to the
11 board have been changed appropriately.

12 (2) V.T.I.C. Article 21.49-2 refers to the
13 authority to "prescribe, adopt, promulgate, and
14 enforce" rules. The revised law omits the references
15 to "prescribe" and "promulgate" because, in context,
16 those terms are included within the meaning of
17 "adopt," and "adopt" is the term used by the
18 Administrative Procedure Act (Chapter 2001,
19 Government Code).

20 (3) V.T.I.C. Article 21.49-2 refers to "rules
21 and regulations." The revised law omits the reference
22 to "regulations" because under Section 311.005(5),
23 Government Code (Code Construction Act), a rule is
24 defined to include a regulation. That definition
25 applies to the revised law.

26 (4) V.T.I.C. Article 21.49-2 provides that the
27 State Board of Insurance may "alter or amend, as it
28 deems necessary, any and all of the rules and
29 regulations prescribed and adopted by it." The
30 revised law omits this provision as unnecessary. The
31 authority to adopt rules includes the authority to
32 alter or amend those rules. The omitted law reads:

33 Art. 21.49-2. . . . The Board shall
34 have authority to alter or amend, as it
35 deems necessary, any and all of the rules
36 and regulations prescribed and adopted by
37 it.

1 Revised Law

2 Sec. 551.002. WRITTEN STATEMENT OF REASONS FOR DECLINATION,
3 CANCELLATION, OR NONRENEWAL. (a) The commissioner shall require
4 an insurer, on request by an applicant for insurance or a
5 policyholder, to provide to the applicant or policyholder a written
6 statement of the reasons for the declination, cancellation, or
7 nonrenewal of an insurance policy to which Section 551.001 applies.

8 (b) An insurer's written statement giving the reasons for
9 the declination, cancellation, or nonrenewal of an insurance policy
10 must fully explain a decision that adversely affects an applicant
11 for insurance or a policyholder by denying the applicant or
12 policyholder insurance coverage or continued coverage.

13 (c) The statement must:

14 (1) state the precise incident, circumstance, or risk
15 factors applicable to the applicant for insurance or the
16 policyholder that violates any applicable guidelines;

17 (2) state the source of information on which the
18 insurer relied regarding the incident, circumstance, or risk
19 factors; and

20 (3) specify any other information considered relevant
21 by the commissioner.

22 (d) The commissioner shall adopt rules as necessary to
23 implement this section. (V.T.I.C. Art. 21.49-2 (part); Art.
24 21.49-2E, Secs. (a) (part), (b).)

25 Source Law

26 Art. 21.49-2. . . . The Board shall require a
27 written statement of the reason or reasons for
28 declination, cancellation, or nonrenewal of any of the
29 policies covered by this article to be given by the
30 insurer to the policyholder or applicant upon request
31 by the policyholder or applicant. . . .

32 Art. 21.49-2E. (a) An insurer's written
33 statement giving the reason or reasons for
34 cancellation, declination, or nonrenewal of an
35 insurance policy required by Articles 21.49-2 . . . of
36 this code shall fully explain a decision which
37 adversely affects an applicant or policyholder by
38 denying the applicant or policyholder coverage or
39 continued coverage, and such statements shall:

40 (1) state the precise incident,
41 circumstance, or risk factor or factors applicable to

1 the applicant or policyholder that violate the
2 guideline or guidelines;

3 (2) state the source of information the
4 insurer relied on regarding the incident,
5 circumstance, or risk factor or factors; and

6 (3) specify any other information deemed
7 relevant by the commissioner.

8 (b) The commissioner is authorized and directed
9 to issue rules necessary to implement this article.

10 Revisor's Note

11 Section (b), V.T.I.C. Article 21.49-2E, states
12 that the commissioner "is authorized and directed to
13 issue rules." Because the article "directs" the
14 commissioner to adopt rules, the law is revised as a
15 statement of a duty required of the commissioner. The
16 revised law uses the term "adopt" rather than "issue"
17 in the context of rules for the reasons stated in
18 Revisor's Note (2) to Section 551.001.

19 Revised Law

20 Sec. 551.003. IMMUNITY FROM LIABILITY. An insurer or agent
21 or an employee of an insurer or agent is not liable, and a cause of
22 action does not arise against that individual or entity, for a
23 statement, disclosure, or communication made in good faith under
24 this subchapter. Immunity under this section does not apply to:

25 (1) disclosure of information known to be false; or

26 (2) a disclosure made with malice or the wilful intent
27 to injure any person. (V.T.I.C. Art. 21.49-2 (part).)

28 Source Law

29 Art. 21.49-2. . . . There shall be no liability
30 on the part of, and no cause of action shall arise
31 against any insurer or agent or employees of the
32 insurer or agent, for any statements, disclosures, or
33 communications made in good faith by them under this
34 article; except there shall be no immunity under this
35 article for a disclosure of information known to be
36 false or a disclosure with malice or wilful intent to
37 injure any person. . . .

38 [Sections 551.004-551.050 reserved for expansion]

39 SUBCHAPTER B. CANCELLATION AND NONRENEWAL OF CERTAIN
40 LIABILITY INSURANCE POLICIES

41 Revised Law

42 Sec. 551.051. DEFINITIONS. In this subchapter:

1 (1) "Insurer" means an insurance company or other
2 entity admitted to engage in business and authorized to write
3 liability insurance in this state, including a county mutual
4 insurance company, a Lloyd's plan, and a reciprocal or
5 interinsurance exchange. The term does not include a county mutual
6 fire insurance company that writes exclusively industrial fire
7 insurance as described by Section 912.310 or a farm mutual
8 insurance company.

9 (2) "Liability insurance" means:

- 10 (A) general liability insurance;
- 11 (B) professional liability insurance other than
12 medical professional liability insurance;
- 13 (C) commercial automobile liability insurance;
- 14 (D) commercial multiperil insurance; and
- 15 (E) any other type or line of liability insurance
16 designated by the department. (V.T.I.C. Art. 21.49-2A, Sec. (a).)

17 Source Law

18 Art. 21.49-2A. (a) In this article:

- 19 (1) "Liability insurance" means the
20 following types of insurance:
 - 21 (A) general liability;
 - 22 (B) professional liability other
23 than medical professional liability;
 - 24 (C) commercial automobile liability;
 - 25 (D) commercial multiperil coverage;
- 26 and
- 27 (E) any other types or lines of
28 liability insurance designated by the State Board of
29 Insurance.

30 (2) "Insurer" means each insurance company
31 or other entity admitted to do business and authorized
32 to write liability insurance in this state, including
33 county mutual insurance companies, Lloyd's plan
34 companies, and reciprocal or interinsurance exchanges
35 but excluding farm mutual insurance companies and
36 county mutual fire insurance companies writing
37 exclusively industrial fire insurance as defined by
38 Article 17.02 of this code.

39 Revised Law

40 Sec. 551.052. CANCELLATION PROHIBITED; EXCEPTIONS. (a)
41 An insurer may not cancel a liability insurance policy that is a
42 renewal or continuation policy.

43 (b) An insurer may not cancel a liability insurance policy
44 during the initial policy term after the 60th day following the date

1 on which the policy was issued.

2 (c) Notwithstanding Subsections (a) and (b), an insurer may
3 cancel a liability insurance policy at any time during the term of
4 the policy for:

- 5 (1) fraud in obtaining coverage;
- 6 (2) failure to pay premiums when due;
- 7 (3) an increase in hazard within the control of the
8 insured that would produce a rate increase; or
- 9 (4) loss of the insurer's reinsurance covering all or
10 part of the risk covered by the policy.

11 (d) Notwithstanding Subsections (a) and (b), an insurer may
12 cancel a liability insurance policy at any time during the term of
13 the policy if the insurer is placed in supervision,
14 conservatorship, or receivership and the cancellation or
15 nonrenewal is approved or directed by the supervisor, conservator,
16 or receiver. (V.T.I.C. Art. 21.49-2A, Secs. (b), (c).)

17 Source Law

18 (b) Except as provided by Section (c) of this
19 article, an insurer may not cancel:

- 20 (1) a policy of liability insurance that
21 is a renewal or continuation policy; or
- 22 (2) a policy of liability insurance that
23 is in its initial policy period after the 60th day
24 following the date on which the policy was issued.

25 (c) An insurer may cancel the policy at any time
26 during the term of the policy for the following
27 reasons:

- 28 (1) fraud in obtaining coverage;
- 29 (2) failure to pay premiums when due;
- 30 (3) on an increase in hazard within the
31 control of the insured which would produce an increase
32 in rate;
- 33 (4) loss of the insurer's reinsurance
34 covering all or part of the risk covered by the policy;
35 or
- 36 (5) on an insurer being placed in
37 supervision, conservatorship, or receivership, if the
38 cancellation or nonrenewal is approved or directed by
39 the supervisor, conservator, or receiver.

40 Revised Law

41 Sec. 551.053. WRITTEN NOTICE OF CANCELLATION
42 REQUIRED. Not later than the 10th day before the date on which the
43 cancellation of a liability insurance policy takes effect, an
44 insurer must deliver or mail written notice of the cancellation to

1 the first-named insured under the policy at the address shown on the
2 policy. (V.T.I.C. Art. 21.49-2A, Sec. (d).)

3 Source Law

4 (d) An insurer must deliver or mail to the
5 first-named insured under a liability insurance policy
6 at the address shown on the policy written notice of
7 cancellation of the policy not less than the 10th day
8 before the date on which the cancellation takes
9 effect.

10 Revised Law

11 Sec. 551.054. WRITTEN NOTICE OF NONRENEWAL REQUIRED. (a)
12 An insurer may refuse to renew a liability insurance policy if the
13 insurer delivers or mails written notice of the nonrenewal to the
14 first-named insured under the policy at the address shown on the
15 policy.

16 (b) The notice must be delivered or mailed not later than
17 the 60th day before the date on which the policy expires. If the
18 notice is delivered or mailed later than the 60th day before the
19 date on which the policy expires, the coverage remains in effect
20 until the 61st day after the date on which the notice is delivered
21 or mailed.

22 (c) Earned premium for any period of coverage that extends
23 beyond the expiration date of the policy shall be computed pro rata
24 based on the previous year's rate. (V.T.I.C. Art. 21.49-2A, Sec.
25 (e).)

26 Source Law

27 (e) An insurer may refuse to renew a policy if
28 the insurer delivers or mails to the first-named
29 insured written notice of the nonrenewal of the policy
30 at the address shown on the policy. The notice must be
31 delivered or mailed not later than the 60th day before
32 the date on which the policy expires. If notice is
33 delivered or mailed later than the 60th day before the
34 date on which the policy expires, the coverage shall
35 remain in effect until the 61st day after the date on
36 which the notice is delivered or mailed. Earned
37 premium for any period of coverage that extends beyond
38 the expiration date of the policy shall be computed pro
39 rata based on the previous year's rate.

40 Revised Law

41 Sec. 551.055. REASON FOR CANCELLATION OR NONRENEWAL
42 REQUIRED. In a notice to an insured relating to cancellation or

1 refusal to renew, an insurer must state the reason for the
2 cancellation or nonrenewal. The statement must comply with:

- 3 (1) Sections 551.002(b) and (c); and
- 4 (2) rules adopted under Section 551.002(d). (V.T.I.C.
5 Art. 21.49-2A, Sec. (g); Art. 21.49-2E, Sec. (a) (part).)

6 Source Law

7 [Art. 21.49-2A]

8 (g) In notice to an insured relating to
9 cancellation or refusal to renew, the insurer must
10 state the reason for the cancellation or nonrenewal.

11 Art. 21.49-2E. (a) [An insurer's written
12 statement giving the reason or reasons for
13 cancellation, declination, or nonrenewal of an
14 insurance policy required by Articles 21.49-2,
15 21.49-2A, and [21.49-2B of this code shall fully
16 explain a decision which adversely affects an
17 applicant or policyholder by denying the applicant or
18 policyholder coverage or continued coverage, and such
19 statements shall:]

20 . . .

21 Revised Law

22 Sec. 551.056. TRANSFER NOT CONSIDERED REFUSAL TO
23 RENEW. For purposes of this subchapter, the transfer of a
24 policyholder between admitted companies within the same insurance
25 group is not considered a refusal to renew. (V.T.I.C. Art.
26 21.49-2A, Sec. (f).)

27 Source Law

28 (f) For purposes of this article, the transfer
29 of a policyholder between admitted companies within
30 the same insurance group is not considered a refusal to
31 renew.

32 [Sections 551.057-551.100 reserved for expansion]

33 SUBCHAPTER C. CANCELLATION AND NONRENEWAL OF CERTAIN PROPERTY
34 AND CASUALTY POLICIES

35 Revised Law

36 Sec. 551.101. DEFINITION. In this subchapter, "insurer"
37 means any authorized insurer writing property and casualty
38 insurance in this state, including:

- 39 (1) a county mutual insurance company;
- 40 (2) a Lloyd's plan;
- 41 (3) a reciprocal or interinsurance exchange; and

1 (4) a farm mutual insurance company. (V.T.I.C. Art.
2 21.49-2B, Sec. 1(1).)

3 Source Law

4 Art. 21.49-2B

5 Sec. 1. In this article:

6 (1) "Insurer" means any licensed insurer
7 writing property and casualty insurance in this state,
8 including:

9 (A) a county mutual insurance
10 company;

11 (B) a Lloyd's plan company;

12 (C) a reciprocal or interinsurance
13 exchange; and

14 (D) a farm mutual company.

15 Revisor's Note

16 Section 1(1), V.T.I.C. Article 21.49-2B, refers
17 to a "licensed" insurer writing property and casualty
18 insurance. The revised law substitutes "authorized"
19 for "licensed" for consistency of terminology in this
20 code.

21 Revised Law

22 Sec. 551.102. APPLICABILITY OF SUBCHAPTER. This
23 subchapter applies only to:

24 (1) a personal automobile insurance policy, other than
25 a policy written through the Texas Automobile Insurance Plan
26 Association;

27 (2) a homeowners or farm or ranch owners insurance
28 policy;

29 (3) a standard fire insurance policy insuring:

30 (A) a one-family dwelling or a duplex; or

31 (B) the contents of a one-family dwelling, a
32 duplex, or an apartment; or

33 (4) an insurance policy providing property and
34 casualty coverage, other than a fidelity, surety, or guaranty bond,
35 to:

36 (A) this state;

37 (B) an agency of this state;

38 (C) a political subdivision of this state,
39 including:

- 1 (i) a municipality or county;
- 2 (ii) a school district or junior college
3 district;
- 4 (iii) a levee improvement district,
5 drainage district, or irrigation district;
- 6 (iv) a water improvement district, water
7 control and improvement district, or water control and preservation
8 district;
- 9 (v) a freshwater supply district;
- 10 (vi) a navigation district;
- 11 (vii) a conservation and reclamation
12 district;
- 13 (viii) a soil conservation district;
- 14 (ix) a communication district; and
- 15 (x) a river authority; or

16 (D) any other governmental agency whose
17 authority is derived from the laws or constitution of this state.
18 (V.T.I.C. Art. 21.49-2B, Secs. 1(2), 2.)

19 Source Law

20 Sec. 1. In this article:

21 (2) "Governmental unit" means:

- 22 (A) the state;
- 23 (B) an agency of the state;
- 24 (C) a political subdivision of the
25 state, including a municipality, county, school
26 district, junior college district, levee improvement
27 district, drainage district, irrigation district,
28 water improvement district, water control and
29 improvement district, water control and preservation
30 district, freshwater supply district, navigation
31 district, conservation and reclamation district, soil
32 conservation district, communication district, and
33 river authority; and
- 34 (D) any other agency of government
35 whose authority is derived from the laws or
36 constitution of this state.

37 Sec. 2. This article applies only to:

- 38 (1) a personal automobile insurance
39 policy, other than a policy written through the Texas
40 Automobile Insurance Plan;
- 41 (2) a homeowners or farm or ranch owner's
42 policy;
- 43 (3) a standard fire policy insuring a
44 one-family dwelling, a duplex, or the contents of a
45 one-family dwelling, a duplex, or an apartment; and
- 46 (4) a policy providing property and
47 casualty coverage to a governmental unit, other than a

1 fidelity, surety, or guaranty bond.

2 Revised Law

3 Sec. 551.103. CANCELLATION. For the purposes of this
4 subchapter, an insurer has canceled an insurance policy if the
5 insurer, without the consent of the insured:

6 (1) terminates coverage provided under the policy;

7 (2) refuses to provide additional coverage to which
8 the insured is entitled under the policy; or

9 (3) reduces or restricts coverage under the policy by
10 endorsement or other means. (V.T.I.C. Art. 21.49-2B, Sec. 3.)

11 Source Law

12 Sec. 3. For the purposes of this article, an
13 insurer has cancelled an insurance policy if the
14 insurer, without the consent of the insured:

15 (1) terminates coverage provided under a
16 policy;

17 (2) refuses to provide additional coverage
18 to which the insured is entitled under the policy; or

19 (3) reduces or restricts coverage under a
20 policy by endorsement or other means.

21 Revised Law

22 Sec. 551.104. AUTHORIZED CANCELLATION OF POLICIES. (a) An
23 insurer may cancel an insurance policy only as provided by this
24 section.

25 (b) An insurer may cancel any policy if:

26 (1) the named insured does not pay any portion of the
27 premium when due;

28 (2) the insured submits a fraudulent claim; or

29 (3) the department determines that continuation of the
30 policy would result in a violation of this code or any other law
31 governing the business of insurance in this state.

32 (c) An insurer may cancel a policy, other than a personal
33 automobile insurance policy, if there is an increase in the hazard
34 covered by the policy that is within the control of the insured and
35 that would produce an increase in the premium rate of the policy.

36 (d) An insurer may cancel a personal automobile insurance
37 policy if the driver's license or motor vehicle registration of the
38 named insured or any other motor vehicle operator who resides in the

1 same household as the named insured or who customarily operates an
2 automobile covered by the policy is suspended or revoked. An
3 insurer may not cancel a policy under this subsection if the named
4 insured consents to an endorsement terminating coverage under the
5 policy for the person whose license is suspended or revoked.

6 (e) Cancellation of a policy under Subsection (b), (c), or
7 (d) does not take effect until the 10th day after the date the
8 insurer mails notice of the cancellation to the insured.

9 (f) An insurer may cancel a personal automobile insurance
10 policy effective on any 12-month anniversary of the original
11 effective date of the policy if the insurer mails to the named
12 insured written notice of the cancellation not later than the 30th
13 day before the effective date of the cancellation.

14 (g) An insurer may cancel a personal automobile insurance
15 policy if the policy has been in effect less than 60 days. An
16 insurer may cancel any other insurance policy if the policy has been
17 in effect less than 90 days. (V.T.I.C. Art. 21.49-2B, Sec. 4.)

18 Source Law

19 Sec. 4. (a) An insurer may cancel an insurance
20 policy covered by this article only as provided by this
21 section.

22 (b) An insurer may cancel a policy if the named
23 insured does not pay the premium or any portion of the
24 premium when due.

25 (c) An insurer may cancel a policy if the board
26 determines that continuation of the policy would
27 result in a violation of this code or any other law
28 governing the business of insurance in this state.

29 (d) An insurer may cancel a policy if the
30 insured submits a fraudulent claim.

31 (e) An insurer may cancel a personal automobile
32 insurance policy if the driver's license or motor
33 vehicle registration of the named insured or any other
34 motor vehicle operator who resides in the same
35 household as the named insured or who customarily
36 operates an automobile covered by the policy is
37 suspended or revoked. An insurer may not cancel a
38 policy under this subsection if the named insured
39 consents to an endorsement terminating coverage under
40 the policy for the person whose license is suspended or
41 revoked.

42 (f) An insurer may cancel a policy, other than a
43 personal automobile insurance policy, if there is an
44 increase in the hazard covered by the policy that is
45 within the control of the insured and that would
46 produce an increase in the premium rate of the policy.

47 (g) Cancellation of a policy under Subsection
48 (b), (c), (d), (e), or (f) of this section does not
49 take effect until the 10th day after the date the

1 insurer mails notice of the cancellation to the
2 insured.

3 (h) An insurer may cancel a personal automobile
4 insurance policy with the cancellation taking effect
5 on any 12-month anniversary of the original effective
6 date of the policy but only if the insurer mails to the
7 named insured written notice of the cancellation not
8 later than the 30th day before the effective date of
9 the cancellation.

10 (i) An insurer may cancel a personal automobile
11 insurance policy if it has been in effect less than 60
12 days. An insurer may cancel any other policy if it has
13 been in effect less than 90 days.

14 Revisor's Note

15 Section 4(a), V.T.I.C. Article 21.49-2B, refers
16 to an insurance policy "covered by this article." The
17 revised law omits the quoted language as unnecessary.
18 Section 2, V.T.I.C. Article 21.49-2B, revised as
19 Section 551.102, specifies the insurance policies to
20 which V.T.I.C. Article 21.49-2B, revised as this
21 subchapter, applies.

22 Revised Law

23 Sec. 551.105. NONRENEWAL OF POLICIES; NOTICE
24 REQUIRED. Unless the insurer has mailed written notice of
25 nonrenewal to the insured not later than the 30th day before the
26 date on which the insurance policy expires, an insurer must renew an
27 insurance policy, at the request of the insured, on the expiration
28 of the policy. (V.T.I.C. Art. 21.49-2B, Secs. 5, 11(b).)

29 Source Law

30 Sec. 5. An insurer shall renew a policy on its
31 expiration, at the option of the insured, unless the
32 insurer has mailed written notice of nonrenewal to the
33 insured not later than the 30th day before the date on
34 which the policy expires.

35 [Sec. 11]

36 (b) If an insurer fails to give notice of
37 nonrenewal of a policy as required by Section 5 of this
38 article, the insurer shall renew the policy at the
39 request of the insured.

40 Revised Law

41 Sec. 551.106. RENEWAL OF PERSONAL AUTOMOBILE INSURANCE
42 POLICIES. (a) An insurer may not refuse to renew a personal
43 automobile insurance policy solely because of the age of the person
44 covered by the policy.

1 (b) An insurer shall renew a personal automobile insurance
2 policy that was written for a term of less than one year, except
3 that the insurer may refuse to renew the policy on any 12-month
4 anniversary of the original effective date of the policy.
5 (V.T.I.C. Art. 21.49-2B, Sec. 6.)

6 Source Law

7 Sec. 6. (a) An insurer may not decline to renew
8 a personal automobile insurance policy solely because
9 of the age of the person covered by the policy.

10 (b) An insurer shall renew a personal automobile
11 insurance policy that was written for a period of less
12 than one year, except that the insurer may decline to
13 renew the policy on any 12-month anniversary of the
14 original effective date of the policy.

15 Revised Law

16 Sec. 551.107. RENEWAL OF CERTAIN POLICIES; PREMIUM
17 SURCHARGE AUTHORIZED; NOTICE. (a) This section applies only to a
18 standard fire, homeowners, or farm or ranch owners insurance
19 policy.

20 (b) A claim under this section does not include a claim:

21 (1) resulting from a loss caused by natural causes; or

22 (2) that is filed but is not paid or payable under the
23 policy.

24 (c) An insurer may assess a premium surcharge at the time an
25 insurance policy is renewed if the insured has filed two or more
26 claims in the preceding policy year. The insurer may assess an
27 additional premium surcharge if an additional claim is made in the
28 following policy year. The department shall set the amount of any
29 surcharge that may be assessed under this subsection. The amount of
30 the surcharge may not exceed 10 percent of the total premium,
31 including any premium surcharge, actually paid by the insured in
32 the preceding policy year.

33 (d) Subject to Subsection (e), an insurer may refuse to
34 renew an insurance policy if the insured has filed three or more
35 claims under the policy in any three-year period.

36 (e) An insurer may notify an insured who has filed two
37 claims in a period of less than three years that the insurer may

1 refuse to renew the policy if the insured files a third claim during
2 the three-year period. If the insurer does not notify the insured
3 in accordance with this subsection, the insurer may not refuse to
4 renew the policy because of losses. The notice form must:

5 (1) list the policyholder's claims; and

6 (2) contain the sentence: "Another non-weather
7 related loss could cause us to refuse to renew your policy."

8 (f) An insurer that renews the insurance policy of an
9 insured who has filed three or more claims under the policy in a
10 three-year period may assess a premium surcharge in an amount set by
11 the department. (V.T.I.C. Art. 21.49-2B, Sec. 7.)

12 Source Law

13 Sec. 7. (a) This section applies only to
14 standard fire, homeowners', and farm or ranch owners'
15 insurance policies. A claim under this section does
16 not include:

17 (1) a claim resulting from a loss caused by
18 natural causes; or

19 (2) a claim that is filed but is not paid
20 or payable under the policy.

21 (b) An insurer may assess a premium surcharge at
22 the time a policy is renewed if the insured has filed
23 two or more claims in the preceding policy year. The
24 insurer may assess an additional premium surcharge if
25 an additional claim is made in the following policy
26 year. The board shall set the amount of any surcharge
27 that may be assessed under this subsection, except
28 that the amount of the surcharge may not exceed 10
29 percent of the total premium, including any premium
30 surcharge, actually paid by the insured in the
31 preceding policy year.

32 (c) An insurer may decline to renew a policy if
33 the insured has filed three or more claims under the
34 policy in any three-year period.

35 (d) An insurer may notify an insured who has
36 filed two claims in a period of less than three years
37 that the insurer may decline to renew the policy if the
38 insured files a third claim during the three-year
39 period. If the insurer does not notify the insured in
40 accordance with this subsection, the insurer may not
41 refuse to renew the policy because of losses. The
42 notice form must list the policyholder's claims and
43 contain the sentence: "Another non-weather related
44 loss could cause us to refuse to renew your policy."

45 (e) An insurer that renews the policy of an
46 insured who has filed three or more claims under the
47 policy in a three-year period may assess a premium
48 surcharge in an amount set by the board.

49 Revised Law

50 Sec. 551.108. INSURER RECORDS. (a) An insurer shall
51 maintain information regarding cancellation or nonrenewal of

1 insurance policies in accordance with the insurer's ordinary
2 practices for maintaining records of expired policies.

3 (b) The insurer shall make the information available to the
4 department on request. (V.T.I.C. Art. 21.49-2B, Sec. 8.)

5 Source Law

6 Sec. 8. An insurer shall maintain information
7 concerning cancellation or nonrenewal of policies in
8 accordance with the insurer's ordinary practices for
9 maintaining records of expired policies. The insurer
10 shall make the information available to the department
11 on request.

12 Revised Law

13 Sec. 551.109. INSURER STATEMENT. An insurer shall, at the
14 request of an applicant for insurance or an insured, provide a
15 written statement of the reason for a declination, cancellation, or
16 nonrenewal of an insurance policy. The statement must comply with:

- 17 (1) Sections 551.002(b) and (c); and
- 18 (2) rules adopted under Section 551.002(d). (V.T.I.C.
19 Art. 21.49-2B Sec. 9; Art. 21.49-2E, Sec. (a) (part).)

20 Source Law

21 [Art. 21.49-2B]
22 Sec. 9. An insurer shall, at the request of an
23 insured or an applicant for insurance, provide a
24 written statement of the reason for a cancellation or
25 nonrenewal of or determination not to issue a policy.

26 Art. 21.49-2E. (a) [An insurer's written
27 statement giving the reason or reasons for
28 cancellation, declination, or nonrenewal of an
29 insurance policy required by Articles 21.49-2,
30 21.49-2A, and] 21.49-2B [of this code shall fully
31 explain a decision which adversely affects an
32 applicant or policyholder by denying the applicant or
33 policyholder coverage or continued coverage, and such
34 statements shall:]

35 Revised Law

36 Sec. 551.110. LIABILITY FOR DISCLOSURE. An insurer or
37 agent or an employee of an insurer or agent is not liable for a
38 statement or disclosure made in good faith under this subchapter
39 unless the statement or disclosure was:

- 40 (1) known to be false; or
- 41 (2) made with malice or wilful intent to injure any
42 person. (V.T.I.C. Art. 21.49-2B, Sec. 10.)

1 SUBCHAPTER D. CANCELLATION OR NONRENEWAL OF CERTAIN POLICIES
2 ISSUED TO ELECTED OFFICIALS

3 Revised Law

4 Sec. 551.151. DEFINITION. In this subchapter, "insurer"
5 has the meaning assigned by Section 551.101. (V.T.I.C. Art.
6 21.49-2D, Sec. (a).)

7 Source Law

8 Art. 21.49-2D. (a) In this article, "insurer"
9 has the meaning assigned by Section 1(1), Article
10 21.49-2B, of this code.

11 Revised Law

12 Sec. 551.152. ELECTED OFFICIALS. An insurer may not cancel
13 or refuse to renew an insurance policy based solely on the fact that
14 the policyholder is an elected official. (V.T.I.C. Art. 21.49-2D,
15 Sec. (b).)

16 Source Law

17 (b) An insurer may not cancel or refuse to renew
18 a policy or contract of insurance based solely on the
19 fact that the policyholder in question is an elected
20 official.

21 CHAPTER 552. ILLEGAL PRICING PRACTICES

22 Sec. 552.001. APPLICABILITY OF CHAPTER. 415
23 Sec. 552.002. FRAUDULENT INSURANCE ACT. 415
24 Sec. 552.003. CHARGING DIFFERENT PRICES; OFFENSE 416

25 CHAPTER 552. ILLEGAL PRICING PRACTICES

26 Revised Law

27 Sec. 552.001. APPLICABILITY OF CHAPTER. This chapter does
28 not apply to the provision of a health care service to a:

- 29 (1) Medicaid or Medicare patient; or
30 (2) medically indigent person who qualifies for a
31 sliding fee scale. (V.T.I.C. Art. 21.79F, Sec. (d).)

32 Source Law

33 (d) This article does not apply to the provision
34 of health care services to Medicaid or Medicare
35 patients or to medically indigent persons who qualify
36 for sliding fee scales.

37 Revised Law

38 Sec. 552.002. FRAUDULENT INSURANCE ACT. An offense under

1 Section 552.003 is a fraudulent insurance act under Chapter 701.
2 (V.T.I.C. Art. 21.79F, Sec. (c).)

3 Source Law

4 (c) An offense under this article is a
5 fraudulent insurance act for the purpose of Article
6 1.10D of this code.

7 Revised Law

8 Sec. 552.003. CHARGING DIFFERENT PRICES; OFFENSE. (a) A
9 person commits an offense if:

10 (1) the person knowingly or intentionally charges two
11 different prices for providing the same product or service; and

12 (2) the higher price charged is based on the fact that
13 an insurer will pay all or part of the price of the product or
14 service.

15 (b) An offense under this section is a Class B misdemeanor.

16 (V.T.I.C. Art. 21.79F, Secs. (a), (b).)

17 Source Law

18 Art. 21.79F. (a) A person commits an offense if
19 the person intentionally or knowingly charges two
20 different prices for providing the same product or
21 service, where the higher price is based on the fact
22 that an insurer will pay all or part of the price of the
23 product or service.

24 (b) An offense under this article is a Class B
25 misdemeanor.

26 CHAPTER 553. ENFORCEMENT OF INSURANCE POLICIES REGARDING
27 HOLOCAUST VICTIMS

28 Sec. 553.001. DEFINITIONS 416

29 Sec. 553.002. SUSPENSION OF LIMITATIONS PERIOD 418

30 Sec. 553.003. VIOLATION BY INSURER 419

31 Sec. 553.004. EXAMINATION; ENFORCEMENT 419

32 CHAPTER 553. ENFORCEMENT OF INSURANCE POLICIES REGARDING
33 HOLOCAUST VICTIMS

34 Revised Law

35 Sec. 553.001. DEFINITIONS. In this chapter:

36 (1) "Holocaust victim" means a person who was killed
37 or injured, or who lost financial assets or other property, as the
38 result of discriminatory laws, policies, or actions directed

1 against any discrete group of which the person was a member, during
2 the period of 1920 to 1945, inclusive, in Germany, areas occupied by
3 Germany, or countries allied with Germany.

4 (2) "Insurance policy" includes:

5 (A) a life insurance policy, an annuity, a
6 property insurance policy, a casualty insurance policy, and a
7 liability insurance policy; and

8 (B) reinsurance on a risk covered under a policy
9 described by Paragraph (A).

10 (3) "Insurer" means an insurance company or other
11 entity engaged in the business of insurance or reinsurance in this
12 state. The term includes:

13 (A) a capital stock company, a mutual company, or
14 a Lloyd's plan; and

15 (B) any parent, subsidiary, or affiliated
16 company, at least 50 percent of the stock of which is in common
17 ownership with an insurer engaged in the business of insurance in
18 this state. (V.T.I.C. Art. 21.74, Sec. 1.)

19 Source Law

20 Art. 21.74

21 Sec. 1. In this article:

22 (1) "Holocaust victim" means a person who
23 was killed or injured, or who lost real or personal
24 property or financial assets, as the result of
25 discriminatory laws, policies, or actions directed
26 against any discrete group of which the person was a
27 member, during the period of 1920 to 1945, inclusive,
28 in Germany, areas occupied by Germany, or countries
29 allied with Germany.

30 (2) "Insurer" means an insurance company
31 or other entity engaged in the business of insurance or
32 reinsurance in this state. The term includes:

33 (A) a capital stock company, a mutual
34 company, or a Lloyd's plan; and

35 (B) any parent, subsidiary, or
36 affiliated company, at least 50 percent of the stock of
37 which is in common ownership with an insurer engaged in
38 the business of insurance in this state.

39 (3) "Insurance policy" includes a life
40 insurance policy, an annuity, a property insurance
41 policy, a casualty insurance policy, and a liability
42 insurance policy. The term includes reinsurance on a
43 risk covered under such a policy.

44 Revisor's Note

45 Section 1(1), V.T.I.C. Article 21.74, refers to

1 "real or personal property." The revised law omits the
2 reference to "real or personal" and refers only to
3 "property" because under Section 311.005(4),
4 Government Code (Code Construction Act), "property"
5 includes "real property" and "personal property."

6 Revised Law

7 Sec. 553.002. SUSPENSION OF LIMITATIONS PERIOD. (a)
8 Notwithstanding any other law, a Holocaust victim, or the heir,
9 assignee, beneficiary, or successor of a Holocaust victim, who
10 resides in this state and has a claim arising out of an insurance
11 policy purchased or in effect in Europe before 1946 that was
12 delivered, issued for delivery, or renewed by an insurer may bring
13 an action in this state against an insurer to recover on that claim.

14 (b) An action brought under this section before December 31,
15 2012, may not be dismissed for failure to comply with any applicable
16 limitations period. (V.T.I.C. Art. 21.74, Sec. 2.)

17 Source Law

18 Sec. 2. (a) Notwithstanding any other law, a
19 Holocaust victim, or the heir, assignee, beneficiary,
20 or successor of a Holocaust victim, who resides in this
21 state and has a claim arising out of an insurance
22 policy purchased or in effect in Europe before 1946
23 that was delivered, issued for delivery, or renewed by
24 an insurer may bring an action against an insurer to
25 recover on that claim in a court of competent
26 jurisdiction in this state.

27 (b) An action brought under Subsection (a) of
28 this section may not be dismissed for failure to comply
29 with any applicable limitations period if the action
30 is brought before December 31, 2012.

31 Revisor's Note

32 Section 2(a), V.T.I.C. Article 21.74, refers to
33 an action brought "in a court of competent
34 jurisdiction." The revised law omits the quoted
35 language as unnecessary because an action may only be
36 brought in a court, and the general laws of civil
37 jurisdiction determine which courts have jurisdiction
38 over the matter. For example, see Sections
39 24.007-24.011, Government Code, for the general
40 jurisdiction of district courts.

1 Revised Law

2 Sec. 553.003. VIOLATION BY INSURER. An insurer violates
3 this chapter if the insurer fails to comply with a claim brought
4 under this chapter by:

5 (1) denying the claim on the grounds that the claim is
6 not timely; or

7 (2) asserting a statute of limitations defense in an
8 action brought under Section 553.002. (V.T.I.C. Art. 21.74, Sec.
9 3(a).)

10 Source Law

11 Sec. 3. (a) Failure by an insurer to comply
12 with a claim brought under this article by denying the
13 claim on the grounds that the claim is not timely or by
14 asserting a statute of limitations defense in an
15 action brought under Section 2(a) of this article
16 constitutes a violation of this article.

17 Revised Law

18 Sec. 553.004. EXAMINATION; ENFORCEMENT. (a) If the
19 commissioner considers it necessary, the commissioner may initiate
20 an examination of an insurer under Article 1.15.

21 (b) If the commissioner believes that an insurer is
22 violating or has violated this chapter, the commissioner may:

23 (1) impose a sanction under Chapter 82;

24 (2) issue a cease and desist order under Chapter 83;

25 (3) assess an administrative penalty under Chapter 84;

26 or

27 (4) refer the matter to the attorney general for
28 appropriate enforcement. (V.T.I.C. Art. 21.74, Secs. 3(b), (c).)

29 Source Law

30 (b) If the commissioner considers it to be
31 necessary, the commissioner may initiate an
32 examination under Article 1.15 of this code.

33 (c) If the commissioner believes that a
34 violation of this article by an insurer has occurred or
35 is occurring, the commissioner may:

36 (1) impose sanctions under Chapter 82 of
37 this code;

38 (2) issue a cease and desist order under
39 Chapter 83 of this code;

40 (3) assess an administrative penalty under
41 Chapter 84 of this code; or

42 (4) refer the matter to the attorney
43 general for appropriate enforcement.

1 CHAPTER 554. BURDEN OF PROOF AND PLEADING
2 Sec. 554.001. APPLICABILITY OF CHAPTER. 420
3 Sec. 554.002. BURDEN OF PROOF AND PLEADING. 422

4 CHAPTER 554. BURDEN OF PROOF AND PLEADING
5 Revised Law

6 Sec. 554.001. APPLICABILITY OF CHAPTER. This chapter
7 applies to each insurer or health maintenance organization engaged
8 in the business of insurance or the business of a health maintenance
9 organization in this state, regardless of form and however
10 organized, including:

- 11 (1) a stock life, health, or accident insurance
12 company;
- 13 (2) a mutual life, health, or accident insurance
14 company;
- 15 (3) a stock fire or casualty insurance company;
- 16 (4) a mutual fire or casualty insurance company;
- 17 (5) a Mexican casualty insurance company;
- 18 (6) a Lloyd's plan;
- 19 (7) a reciprocal or interinsurance exchange;
- 20 (8) a fraternal benefit society;
- 21 (9) a title insurance company;
- 22 (10) an attorney's title insurance company;
- 23 (11) a stipulated premium company;
- 24 (12) a nonprofit legal services corporation;
- 25 (13) a statewide mutual assessment company;
- 26 (14) a local mutual aid association;
- 27 (15) a local mutual burial association;
- 28 (16) an association exempt under Section 887.102;
- 29 (17) a nonprofit hospital, medical, or dental service
30 corporation, including a corporation subject to Chapter 842;
- 31 (18) a county mutual insurance company;
- 32 (19) a farm mutual insurance company; and
- 33 (20) an insurer or health maintenance organization

1 engaged in the business of insurance or the business of a health
2 maintenance organization in this state that does not hold a
3 certificate of authority issued by the department or is not
4 otherwise authorized to engage in business in this state.
5 (V.T.I.C. Art. 21.58, Subsec. (a).)

6 Source Law

7 Art. 21.58. (a) This article applies to any
8 insurer doing business in this state, including:

9 (1) a domestic or foreign, stock and
10 mutual, life, health, or accident insurance company;

11 (2) a domestic or foreign, stock and
12 mutual, fire and casualty insurance company;

13 (3) a Mexican casualty company;

14 (4) a domestic or foreign Lloyd's plan
15 insurer;

16 (5) a domestic or foreign or reciprocal or
17 interinsurance exchange;

18 (6) a domestic or foreign fraternal
19 benefit society;

20 (7) a domestic or foreign title insurance
21 company;

22 (8) an attorney's title insurance company;

23 (9) a stipulated premium insurance
24 company;

25 (10) a nonprofit legal service
26 corporation;

27 (11) a statewide mutual assessment
28 company;

29 (12) a local mutual aid association;

30 (13) a local mutual burial association;

31 (14) an association exempt under Article
32 14.17 of this code;

33 (15) a nonprofit hospital, medical, or
34 dental service corporation, including a company
35 subject to Chapter 20 of this code;

36 (16) a health maintenance organization;

37 (17) a county mutual insurance company;

38 (18) a farm mutual insurance company; or

39 (19) an insurer doing business in this
40 state that does not hold a certificate of authority
41 from the department. It is intended that this article
42 apply to all insurance companies doing business in
43 this state, regardless of form and however organized,
44 including insurers not authorized to do business in
45 this state.

46 Revisor's Note

47 (1) Subsection (a), V.T.I.C. Article 21.58,
48 provides that "insurer" includes certain "domestic or
49 foreign" insurers. The revised law omits the
50 reference to "domestic or foreign" as unnecessary.
51 Because the revised law applies to all insurers
52 engaged in business in this state, it is not necessary
53 to distinguish between domestic and foreign insurers

1 in this section.

2 (2) Subsection (a), V.T.I.C. Article 21.58,
3 refers to "any insurer doing business in this state,"
4 including various listed entities. Included among the
5 listed entities is a "health maintenance
6 organization," which is not a traditional insurer.
7 The revised law accordingly substitutes a reference to
8 an "insurer or health maintenance organization" and
9 makes other necessary conforming changes throughout
10 this chapter.

11 Revised Law

12 Sec. 554.002. BURDEN OF PROOF AND PLEADING. In a suit to
13 recover under an insurance or health maintenance organization
14 contract, the insurer or health maintenance organization has the
15 burden of proof as to any avoidance or affirmative defense that the
16 Texas Rules of Civil Procedure require to be affirmatively pleaded.
17 Language of exclusion in the contract or an exception to coverage
18 claimed by the insurer or health maintenance organization
19 constitutes an avoidance or an affirmative defense. (V.T.I.C. Art.
20 21.58, Subsec. (b).)

21 Source Law

22 (b) In any suit to recover under a contract of
23 insurance, the insurer has the burden of proof as to
24 any avoidance or affirmative defense that must be
25 affirmatively pleaded under the Texas Rules of Civil
26 Procedure. Any language of exclusion in the policy and
27 any exception to coverage claimed by the insurer
28 constitutes an avoidance or an affirmative defense.

29 Revisor's Note

30 Subsection (b), V.T.I.C. Article 21.58, refers to
31 "a contract of insurance" and a "policy," which are
32 types of documents that are not typically used by
33 health maintenance organizations. The revised law
34 substitutes references to "an insurance or health
35 maintenance organization contract" and a "contract" to
36 reflect the clear intent of the legislature to apply
37 the substance of the provision to health maintenance

1 organizations and the documents used by health
2 maintenance organizations.

3 CHAPTER 555. FAILURE TO SATISFY JUDGMENT

4 Sec. 555.001. APPLICABILITY OF CHAPTER. 423

5 Sec. 555.002. REVOCATION OF CERTIFICATE OF AUTHORITY. 423

6 CHAPTER 555. FAILURE TO SATISFY JUDGMENT

7 Revised Law

8 Sec. 555.001. APPLICABILITY OF CHAPTER. This chapter does
9 not apply to an insurer subject to Chapter 841. (V.T.I.C. Art.
10 21.36 (part).)

11 Source Law

12 Art. 21.36. [Should any insurance company,
13 except those designated in Article 3.61 of this
14 code

15 Revisor's Note

16 V.T.I.C. Article 21.36 refers to insurance
17 companies "designated in Article 3.61 of this code."
18 V.T.I.C. Article 3.61, revised as Section 841.703,
19 applied to "any life insurance company, accident
20 insurance company, life and accident, health and
21 accident, or life, health and accident insurance
22 company." The provisions of Article 3.61 and related
23 articles were revised in Chapter 841, which applies to
24 life, health, or accident insurance companies. For
25 the reader's convenience, the revised law substitutes
26 a reference to Chapter 841 for the reference to Article
27 3.61.

28 Revised Law

29 Sec. 555.002. REVOCATION OF CERTIFICATE OF AUTHORITY. If
30 an execution issued on a final judgment rendered against an insurer
31 is not satisfied and discharged before the 31st day after the date
32 of notice of the execution's issuance, the insurer's certificate of
33 authority shall be revoked, and the insurer may not engage in the
34 business of insurance in this state until the execution is
35 satisfied. (V.T.I.C. Art. 21.36 (part).)

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Source Law

Art. 21.36. Should any insurance company, . . . fail or neglect to pay off and discharge any execution, issued upon a valid final judgment against said company, within thirty (30) days after the notice of the issuance thereof, then in that event the certificate of authority of said company to transact business of insurance shall be revoked, cancelled and annulled, and said company shall be prohibited from transacting business of insurance in this State until said execution be satisfied.

Revisor's Note

(1) V.T.I.C. Article 21.36 provides for revocation of a certificate of authority of a company that fails to "pay off" an execution. The revised law substitutes "satisfy" for the quoted language because, in context, the meaning is the same and "satisfy" is consistent with the use of similar terminology throughout this code.

(2) V.T.I.C. Article 21.36 refers to a "valid" judgment. The revised law omits "valid" as unnecessary because the word does not add to the clear meaning of the law. An invalid judgment is not a judgment.

(3) V.T.I.C. Article 21.36 provides that under certain circumstances a company's certificate of authority shall be "revoked, cancelled and annulled." The revised law omits "cancelled and annulled" as unnecessary because, in context, "cancelled" and "annulled" are included within the meaning of "revoked."

CHAPTER 556. UNFAIR METHODS OF COMPETITION AND UNFAIR PRACTICES
BY FINANCIAL INSTITUTIONS

SUBCHAPTER A. GENERAL PROVISIONS

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20 CHAPTER 556. UNFAIR METHODS OF COMPETITION AND UNFAIR
21 PRACTICES BY FINANCIAL INSTITUTIONS

22 SUBCHAPTER A. GENERAL PROVISIONS

23 Revised Law

24 Sec. 556.001. DEFINITIONS. In this chapter:

25 (1) "Affiliate" means a person who, directly or
26 indirectly or through one or more intermediaries, controls or is
27 controlled by another person or is under common control with
28 another person.

29 (2) "Depository institution" has the meaning assigned
30 by Section 4001.003. (V.T.I.C. Art. 21.21-9, Sec. 1, as added Acts
31 75th Leg., R.S., Ch. 596.)

32 Source Law

33 Art. 21.21-9

34 Sec. 1. In this article:

35 (1) "Affiliate" means a person who,

1 directly or indirectly or through one or more
2 intermediaries, controls or is controlled by another
3 person or is under common control with another person.

4 (2) "Bank" means a depository institution
5 as defined by Article 21.07 of this code.

6 Revisor's Note

7 Section 1(2), V.T.I.C. Article 21.21-9, as added
8 by Chapter 596, Acts of the 75th Legislature, Regular
9 Session, 1997, defines "bank" by incorporating the
10 definition of "depository institution" from V.T.I.C.
11 Article 21.07, revised in relevant part as Section
12 4001.003 of this code. "Depository institution," as
13 defined by Article 21.07, includes banks and several
14 other types of financial institutions. The revised
15 law substitutes "depository institution" for "bank" as
16 the defined term and uses that term throughout this
17 chapter to more accurately describe the entities to
18 which this chapter applies.

19 Revised Law

20 Sec. 556.002. RULES. The commissioner may adopt
21 reasonable rules to comply with federal law applicable to the sale
22 of insurance and for the implementation and administration of this
23 chapter. (V.T.I.C. Art. 21.21-9, Sec. 7, as added Acts 75th Leg.,
24 R.S., Ch. 596.)

25 Source Law

26 Sec. 7. The commissioner may adopt reasonable
27 rules to comply with federal law applicable to the sale
28 of insurance and for the implementation and
29 administration of this article.

30 [Sections 556.003-556.050 reserved for expansion]

31 SUBCHAPTER B. UNFAIR METHODS OR PRACTICES

32 Revised Law

33 Sec. 556.051. UNFAIR METHOD OF COMPETITION OR UNFAIR
34 PRACTICE: TYING. (a) A depository institution engages in an
35 unfair method of competition or an unfair practice in the sale of
36 insurance by the depository institution if the depository
37 institution:

38 (1) is an agent and, as a condition of extending or

1 renewing credit, leasing or selling property, or furnishing
2 services, requires the purchase of insurance from the depository
3 institution or a subsidiary or affiliate of the depository
4 institution, or from or through a particular agent, insurer, or any
5 other person or entity;

6 (2) conditions the terms of credit or the sale or lease
7 of property on acquisition of insurance from or through the
8 depository institution, a subsidiary or affiliate of the depository
9 institution, or any other particular person or entity;

10 (3) rejects a required policy solely because the
11 policy has been issued or underwritten by a person or entity that is
12 not associated with the depository institution; or

13 (4) imposes a requirement on an agent or broker who is
14 not associated with the depository institution that is not imposed
15 on an agent or broker who is associated with the depository
16 institution or a subsidiary or affiliate of the depository
17 institution.

18 (b) This section does not prevent a person who lends money
19 or extends credit from placing insurance on property if the
20 mortgagor, borrower, or purchaser fails to provide required
21 insurance in accordance with the terms of the loan or credit
22 document. (V.T.I.C. Art. 21.21-9, Secs. 2(a) (part), (b), as added
23 Acts 75th Leg., R.S., Ch. 596.)

24 Source Law

25 Sec. 2. (a) The following are unfair methods of
26 competition and unfair practices in the sale of
27 insurance by banks:

28 (1) Tying. (A) When the agent is a bank,
29 requiring the purchase of insurance from the bank, its
30 subsidiary or affiliate, or from or through any
31 particular agent, solicitor, insurer, or any other
32 person or entity, as a condition of extending or
33 renewing credit, leasing or selling property, or
34 furnishing services;

35 (B) Conditioning the terms of credit
36 or the sale or lease of property on acquisition of
37 insurance from or through the bank, its subsidiary or
38 affiliate, or any other particular person or entity;

39 (C) Rejecting any required policy
40 solely because that policy has been issued or
41 underwritten by a person or entity who is not
42 associated with the bank; or

43 (D) Imposing any requirement on an

1 agent or broker not associated with the bank that is
2 not imposed on an agent or broker who is associated
3 with the bank or the bank's subsidiary or affiliate;
4 and
5

6 (b) Subsection (a)(1) of this section does not
7 prevent a person who lends money or extends credit from
8 placing insurance on real or personal property if the
9 mortgagor, borrower, or purchaser has failed to
10 provide required insurance in accordance with the
11 terms of the loan or credit document.

12 Revisor's Note

13 (1) Section 2(a)(1), V.T.I.C. Article 21.21-9,
14 as added by Chapter 596, Acts of the 75th Legislature,
15 Regular Session, 1997, refers to the purchase of
16 insurance from or through "any particular agent,
17 solicitor, insurer, or any other person or entity."
18 The revised law omits the reference to "solicitor"
19 because that term, as it relates to a particular type
20 of person engaged in the business of insurance, was
21 eliminated by Chapter 703, Acts of the 77th
22 Legislature, Regular Session, 2001, and a person who
23 performs the duties formerly performed by a solicitor
24 is now regulated as an "agent."

25 (2) Section 2(b), V.T.I.C. Article 21.21-9, as
26 added by Chapter 596, Acts of the 75th Legislature,
27 Regular Session, 1997, refers to insurance on "real or
28 personal property." The revised law omits the
29 reference to "real or personal" because under Section
30 311.005(4), Government Code (Code Construction Act),
31 "property" includes both real and personal property.
32 That definition applies to the revised law.

33 Revised Law

34 Sec. 556.052. UNFAIR METHOD OF COMPETITION OR UNFAIR
35 PRACTICE: FAILURE TO DISCLOSE. A depository institution engages
36 in an unfair method of competition or an unfair practice in the sale
37 of insurance by the depository institution if, on the premises of
38 the depository institution or in connection with a product offering
39 of the depository institution, the depository institution sells or

1 solicits the purchase of insurance or a person sells or solicits the
2 purchase of insurance recommended or sponsored by the depository
3 institution and the depository institution or person fails to
4 clearly disclose in all promotional materials relating to an
5 insurance product distributed to customers and potential customers
6 that:

7 (1) an insurance product sold through or in the
8 depository institution or a subsidiary or affiliate of the
9 depository institution is not insured by the Federal Deposit
10 Insurance Corporation;

11 (2) the insurance product is not issued, guaranteed,
12 or underwritten by the depository institution or the Federal
13 Deposit Insurance Corporation; and

14 (3) the insurance product involves investment risk, if
15 appropriate, including potential loss of principal. (V.T.I.C. Art.
16 21.21-9, Sec. 2(a) (part), as added Acts 75th Leg., R.S., Ch. 596.)

17 Source Law

18 (a) The following are unfair methods of
19 competition and unfair practices in the sale of
20 insurance by banks:

21 . . .
22 (2) Bank affiliated agent disclosures.
23 When a bank is soliciting the purchase of or is selling
24 insurance, or any person is soliciting the purchase of
25 or is selling insurance recommended or sponsored by
26 the bank, on the premises of the bank, or in connection
27 with a product offering of the bank, failing to
28 disclose clearly in all promotional materials relating
29 to insurance products that are distributed to
30 customers and potential customers that:

31 (A) insurance products sold through
32 or in the bank or its subsidiary or affiliate are not
33 insured by the Federal Deposit Insurance Corporation;

34 (B) the products are not issued,
35 guaranteed, or underwritten by the bank or the Federal
36 Deposit Insurance Corporation; and

37 (C) the products involve investment
38 risk, if appropriate, including potential loss of
39 principal.

40 [Sections 556.053-556.100 reserved for expansion]

41 SUBCHAPTER C. REGULATION OF PRACTICES

42 Revised Law

43 Sec. 556.101. PROHIBITION ON CERTAIN REFERRALS OR
44 SOLICITATIONS TO PURCHASE INSURANCE. (a) An individual who is an

1 employee or agent of a depository institution or a subsidiary or
2 affiliate of a depository institution may not directly or
3 indirectly make a referral related to insurance to, or solicit the
4 purchase of any insurance by, a customer knowing that the customer
5 has applied for a loan or other extension of credit from a financial
6 institution, before:

7 (1) the customer receives a written commitment
8 relating to that loan or extension of credit; or

9 (2) if a written commitment has not been or will not be
10 issued in connection with the loan or extension of credit, the
11 customer receives notification of approval of that loan or
12 extension of credit by the financial institution and the financial
13 institution creates a written record of the approval.

14 (b) This section does not prohibit a depository institution
15 from:

16 (1) informing a customer that insurance is required in
17 connection with a loan;

18 (2) contacting a person in the course of a direct or
19 mass mailing to a group of persons in a manner that is not related to
20 the person's loan application or credit decision; or

21 (3) selling credit life, credit disability, credit
22 property, or involuntary unemployment insurance that is:

23 (A) specifically authorized by this code;

24 (B) approved for sale in this state; and

25 (C) sold in connection with a credit transaction.

26 (c) This section does not apply to an insurance policy
27 described by Section 556.151. (V.T.I.C. Art. 21.21-9, Secs. 3(c),
28 (e) (part), as added Acts 75th Leg., R.S., Ch. 596.)

29 Source Law

30 (c) An individual who is an employee or agent of
31 a bank, or a subsidiary or affiliate of a bank, may
32 not, directly or indirectly, make an insurance-related
33 referral related to, or solicit the purchase of any
34 insurance from, a customer knowing that the customer
35 has applied for a loan or extension of credit from a
36 financial institution, before the customer has
37 received a written commitment with respect to that
38 loan or extension of credit, or, if a written

1 commitment has not been or will not be issued in
2 connection with the loan or extension of credit,
3 before the customer receives notification of approval
4 of the loan or extension of credit by the person and
5 that person creates a written record of the loan or
6 extension of credit approval. This subsection does
7 not prohibit a bank from:

8 (1) informing a customer that insurance is
9 required in connection with a loan;

10 (2) contacting persons in the course of a
11 direct or mass mailing to a group of persons in a
12 manner that is not related to the person's loan
13 application or credit decision; or

14 (3) selling credit life, credit
15 disability, credit property, or involuntary
16 unemployment insurance specifically authorized by
17 this code and approved for sale in this state, that is
18 sold in conjunction with a credit transaction.

19 (e) This section does not apply to a credit
20 life, credit accident and health, credit property, or
21 credit involuntary unemployment insurance policy
22 [that is otherwise specifically authorized by this
23 code, approved for sale in this state, and sold in
24 connection with a credit transaction].

25 Revisor's Note

26 Section 3(c), V.T.I.C. Article 21.21-9, as added
27 by Chapter 596, Acts of the 75th Legislature, Regular
28 Session, 1997, provides that certain actions may not
29 be taken in relation to a customer who has not been or
30 will not be issued a written commitment in connection
31 with a loan or extension of credit for which the
32 customer has applied "before the customer receives
33 notification of approval of the loan or extension of
34 credit by the person and that person creates a written
35 record of the loan or extension of credit approval."
36 In context, it is clear that "person" in the quoted
37 language means the "financial institution" from which
38 the customer has applied for the loan or extension of
39 credit, and the revised law is drafted accordingly.

40 Revised Law

41 Sec. 556.102. INSURANCE SALE WITH LOAN TRANSACTION. (a)
42 If insurance is offered or sold to a depository institution's
43 customer in connection with a loan transaction by the depository
44 institution, the insurance salesperson involved in that insurance
45 transaction may not be involved in that loan transaction and may not

1 be the person making that loan.

2 (b) This section does not apply to:

3 (1) a depository institution that has \$40 million or
4 less in total assets, as reported in the most recent Consolidated
5 Report of Condition and Income by the Federal Financial
6 Institutions Examination Council or any successor report required
7 by federal or state law; or

8 (2) a credit life, credit disability, credit property,
9 or involuntary unemployment insurance product that is:

10 (A) specifically authorized by this code;

11 (B) approved for sale in this state; and

12 (C) sold in connection with a credit transaction.

13 (V.T.I.C. Art. 21.21-9, Sec. 4, as added Acts 75th Leg., R.S., Ch.
14 596.)

15 Source Law

16 Sec. 4. (a) If insurance is offered or sold to a
17 bank customer in connection with a loan transaction by
18 a bank, the insurance sales person involved in that
19 insurance transaction may not be involved in that loan
20 transaction and may not also be the person making that
21 loan.

22 (b) This section does not apply to a bank that
23 has \$40 million or less in total assets, as reported on
24 the most recent Federal Financial Institutions
25 Examination Council (FFIEC) Consolidated Report of
26 Condition and Income or any successor report required
27 by federal or state law. In addition, this section
28 does not apply to a credit life, credit disability,
29 credit property, or involuntary unemployment
30 insurance product that is specifically authorized by
31 this code, approved for sale in this state, and sold in
32 conjunction with a credit transaction.

33 Revised Law

34 Sec. 556.103. DESIGNATION OF PLACE OF INSURANCE
35 ACTIVITIES. (a) The place where a depository institution sells or
36 solicits the purchase of insurance or the place on the premises of a
37 depository institution where insurance is sold or solicited for
38 purchase shall be clearly and conspicuously indicated by signs so
39 that the public can readily distinguish the sale or solicitation as
40 separate from the lending and deposit-taking activities of the
41 depository institution.

42 (b) The commissioner may grant a waiver from the

1 requirements of this section to a person who files a written request
2 that:

3 (1) demonstrates that, due to the size of the physical
4 premises of the person, compliance with the requirements is not
5 possible; and

6 (2) identifies other steps that will be taken to
7 minimize customer confusion. (V.T.I.C. Art. 21.21-9, Sec. 6, as
8 added Acts 75th Leg., R.S., Ch. 596.)

9 Source Law

10 Sec. 6. The place of solicitation or sale of
11 insurance by a bank or on the premises of a bank must be
12 clearly and conspicuously indicated by signs in order
13 to be readily distinguishable by the public as
14 separate and distinct from the lending and
15 deposit-taking activities of the bank. If a person who
16 would otherwise be subject to the requirements of this
17 section does not have the physical space to comply, the
18 commissioner may grant a waiver from the requirements
19 of this section on written request by that person
20 demonstrating that, due to the size of the physical
21 premises of the person, compliance is not possible if
22 the person also identifies other steps that will be
23 taken to minimize customer confusion.

24 Revisor's Note

25 Section 6, V.T.I.C. Article 21.21-9, as added by
26 Chapter 596, Acts of the 75th Legislature, Regular
27 Session, 1997, requires signs to indicate to the
28 public that the sale of insurance is "separate and
29 distinct" from the traditional activities of a
30 depository institution. The revised law omits
31 "distinct" because in this context "separate" and
32 "distinct" are synonymous.

33 Revised Law

34 Sec. 556.104. USE OF CUSTOMER INFORMATION. (a) In this
35 section:

36 (1) "Customer" means a person with an investment,
37 security, deposit, trust, or credit relationship with a financial
38 institution.

39 (2) "Nonpublic customer information" means
40 information relating to an individual that is derived from a bank

1 record, including information concerning insurance premiums, the
2 terms and conditions of insurance coverage, insurance expirations,
3 insurance claims, and insurance history of the individual. The
4 term does not include a customer's name, address, or telephone
5 number.

6 (b) A person may not use nonpublic customer information for
7 the purpose of selling or soliciting the purchase of insurance, or
8 provide nonpublic customer information to a third party for the
9 purpose of another's selling or soliciting the purchase of
10 insurance, unless:

11 (1) it is clearly and conspicuously disclosed that the
12 nonpublic customer information may be used for that purpose; and

13 (2) the customer has been provided an opportunity to
14 object before the time the information is used. (V.T.I.C. Art.
15 21.21-9, Sec. 5, as added Acts 75th Leg., R.S., Ch. 596.)

16 Source Law

17 Sec. 5. (a) In this section:

18 (1) "Customer" means a person with an
19 investment, security, deposit, trust, or credit
20 relationship with a financial institution.

21 (2) "Nonpublic customer information"
22 means information regarding an individual that is
23 derived from a bank record. The term does not include
24 customer names, addresses, and telephone numbers but
25 does include information concerning insurance
26 premiums, the terms and conditions of insurance
27 coverage, insurance expirations, insurance claims,
28 and insurance history of the individual.

29 (b) A person may not use nonpublic customer
30 information for the purpose of selling or soliciting
31 the purchase of insurance, or provide nonpublic
32 customer information to a third party for the purpose
33 of another's sale or solicitation of the purchase of
34 insurance, unless it is clearly and conspicuously
35 disclosed that the information may be so used and the
36 customer has been provided an opportunity to object
37 before the use of that information for this purpose.

38 [Sections 556.105-556.150 reserved for expansion]

39 SUBCHAPTER D. DISCLOSURES

40 Revised Law

41 Sec. 556.151. APPLICABILITY OF SUBCHAPTER. This
42 subchapter does not apply to a credit life, credit accident and
43 health, credit property, or credit involuntary unemployment
44 insurance policy that is:

- 1 (1) specifically authorized by this code;
2 (2) approved for sale in this state; and
3 (3) sold in connection with a credit transaction.
4 (V.T.I.C. Art. 21.21-9, Sec. 3(e), as added Acts 75th Leg., R.S.,
5 Ch. 596.)

6 Source Law

7 (e) This section does not apply to a credit
8 life, credit accident and health, credit property, or
9 credit involuntary unemployment insurance policy that
10 is otherwise specifically authorized by this code,
11 approved for sale in this state, and sold in connection
12 with a credit transaction.

13 Revised Law

14 Sec. 556.152. PROMOTIONAL MATERIALS DISCLOSURE. (a) This
15 section applies to each agent that is a depository institution or
16 that, on the premises of a depository institution or in connection
17 with a product offering of a depository institution, sells or
18 solicits the purchase of insurance recommended or sponsored by the
19 depository institution.

20 (b) Promotional materials relating to an insurance product
21 distributed to a customer or potential customer must clearly
22 disclose that an insurance product sold through an agent affiliated
23 with a depository institution:

24 (1) is not insured by the Federal Deposit Insurance
25 Corporation;

26 (2) is not issued, guaranteed, or underwritten by the
27 depository institution or the Federal Deposit Insurance
28 Corporation; and

29 (3) involves investment risk, if appropriate,
30 including potential loss of principal. (V.T.I.C. Art. 21.21-9,
31 Sec. 3(a), as added Acts 75th Leg., R.S., Ch. 596.)

32 Source Law

33 Sec. 3. (a) The following disclosure
34 requirements apply to each agent that is a bank, or
35 that solicits the purchase of or sells insurance
36 recommended or sponsored by a bank, on the premises of
37 a bank, or in connection with a product offering of a
38 bank. Promotional materials relating to insurance
39 products distributed to customers and potential
40 customers must clearly disclose that insurance

1 products sold through the bank affiliated agent:
2 (1) are not insured by the Federal Deposit
3 Insurance Corporation;
4 (2) are not issued, guaranteed, or
5 underwritten by the bank or the Federal Deposit
6 Insurance Corporation; and
7 (3) involve investment risk, if
8 appropriate, including potential loss of principal.

9 Revised Law

10 Sec. 556.153. DISCLOSURE AT TIME OF LOAN APPLICATION. (a)
11 At the time a loan application is made, a depository institution
12 shall provide to the customer a written disclosure as required by
13 this section and Section 556.154.

14 (b) The disclosure must be separate from any loan
15 application or loan document.

16 (c) The depository institution employee who presents the
17 disclosure and the customer shall sign and date the disclosure.

18 (d) The depository institution shall maintain one copy of
19 the disclosure in the loan file and shall provide one copy to the
20 customer. (V.T.I.C. Art. 21.21-9, Sec. 3(b) (part), as added Acts
21 75th Leg., R.S., Ch. 596.)

22 Source Law

23 (b) At the time a loan application is made, a
24 bank shall provide to the customer a written
25 disclosure in substantially the form provided by this
26 subsection. The disclosure form must be separate and
27 apart from any loan application or loan document. The
28 bank employee who presents the disclosure and the
29 customer shall sign and date the disclosure form. One
30 copy of the disclosure form shall be maintained by the
31 bank in the loan file and one copy shall be provided to
32 the customer for his or her records. . . .

33 Revisor's Note

34 Section 3(b), V.T.I.C. Article 21.21-9, as added
35 by Chapter 596, Acts of the 75th Legislature, Regular
36 Session, 1997, requires the disclosure to be "separate
37 and apart" from the loan application or documents. The
38 revised law omits "apart" because in this context
39 "separate" and "apart" are synonymous.

40 Revised Law

41 Sec. 556.154. FORM OF DISCLOSURE. (a) The disclosure
42 required by Section 556.153 must be in substantially the following

1 form:

2 "CUSTOMER DISCLOSURE

3 "You have applied for a loan with the depository institution.
4 As permitted by Title 4, Finance Code, the depository institution
5 is requiring that collateral used to secure the loan be insured to
6 cover the amount of the loan to the extent insurance is available on
7 the property to be insured, against the usual and customary
8 casualty losses.

9 "You have the right to provide this insurance either through
10 existing policies already owned or controlled by you or by
11 obtaining the insurance through any insurance agent or insurer
12 authorized to engage in business in Texas.

13 "The depository institution, through its own insurance
14 agency, can also make this insurance available to you. However,
15 federal and state laws provide that the depository institution
16 cannot require you to obtain insurance through the depository
17 institution, its subsidiary, an affiliate, or any particular
18 unaffiliated third party, either as a condition to obtaining this
19 credit or to obtain special terms or consideration.

20 "Insurance products sold through or in the depository
21 institution or its affiliate or subsidiary are not insured by the
22 Federal Deposit Insurance Corporation and are not issued,
23 guaranteed, or underwritten by the depository institution or the
24 Federal Deposit Insurance Corporation.

25 "You are not required or obligated to purchase insurance from
26 the depository institution or any subsidiary, affiliate, or
27 particular unaffiliated third party as a condition to obtaining
28 your loan, and your decision as to insurance agents will not affect
29 your credit terms in any way.

30 _____
31 Customer Date

32 _____
33 Employee of Depository Institution"

34 (b) The commissioner may amend the disclosure form as

1 necessary to comply with federal or state law. (V.T.I.C. Art.
2 21.21-9, Secs. 3(b) (part), (d), as added Acts 75th Leg., R.S., Ch.
3 596.)

4 Source Law

5 (b) . . . The disclosure must be in
6 substantially the following form:

7 "CUSTOMER DISCLOSURE

8 "You have applied for a loan with the bank. As
9 permitted by the Texas Credit Code, the bank is
10 requiring that collateral used to secure the loan be
11 insured to cover the amount of the loan to the extent
12 insurance is available on the property to be insured,
13 against the usual and customary casualty losses.

14 "You have the right to provide this insurance
15 either through existing policies already owned or
16 controlled by you or by procuring the insurance
17 through any insurance agent or company authorized to
18 transact business in Texas.

19 "The bank, through its own insurance agency, can
20 also make this insurance available to you. However,
21 federal and state laws provide that the bank cannot
22 require you to obtain insurance through the bank, its
23 subsidiary, an affiliate, or any particular
24 unaffiliated third party, either as a condition to
25 obtaining this credit or to obtain special terms or
26 consideration.

27 "Insurance products sold through or in the bank
28 or its affiliate or subsidiary are not insured by the
29 Federal Deposit Insurance Corporation and are not
30 issued, guaranteed, or underwritten by the bank or the
31 Federal Deposit Insurance Corporation.

32 "You are not required or obligated to purchase
33 insurance from the bank or any subsidiary, affiliate,
34 or particular unaffiliated third party as a condition
35 to obtaining your loan, and your decision as to
36 insurance agents will not affect your credit terms in
37 any way.

38 _____
39 Customer Date

40 _____
41 Employee of Bank"

42 (d) The commissioner may amend the disclosure
43 form as necessary to comply with federal or state law.

44 Revisor's Note

45 Section 3(b), V.T.I.C. Article 21.21-9, as added
46 by Chapter 596, Acts of the 75th Legislature, Regular
47 Session, 1997, contains a customer notice that refers
48 to "the Texas Credit Code." Title 79, Revised Statutes
49 (Article 5069-1.01 et seq., Vernon's Texas Civil
50 Statutes), was informally referred to as the Texas
51 Credit Code. The pertinent part of Title 79 was

1 codified as Title 4, Finance Code, in 1997. The
2 revised law is drafted accordingly.

3 CHAPTER 557. INSURED PROPERTY SUBJECT TO SECURITY INTEREST

4 SUBCHAPTER A. INSURANCE PROCEEDS HELD BY LENDER PENDING

5 REPAIR OF RESIDENTIAL REAL PROPERTY

6 Sec. 557.001. DEFINITIONS 439
7 Sec. 557.002. NOTIFICATION BY LENDER TO INSURED CONCERNING
8 INSURANCE PROCEEDS 440
9 Sec. 557.003. LENDER'S RELEASE OR REFUSAL TO RELEASE
10 INSURANCE PROCEEDS 441
11 Sec. 557.004. PAYMENT OF INTEREST; RATE 442
12 Sec. 557.005. ACCRUAL OF INTEREST. 442
13 Sec. 557.006. INTEREST NOT REQUIRED ON INSURANCE PROCEEDS
14 APPLIED TO REDUCE NOTE 443

15 [Sections 557.007-557.050 reserved for expansion]

16 SUBCHAPTER B. LIENHOLDER APPROVAL OF INSURANCE CLAIM PAYMENT

17 RELATING TO PERSONAL PROPERTY

18 Sec. 557.051. LIENHOLDER APPROVAL OF PAYMENT 444
19 Sec. 557.052. CIVIL PENALTY 444

20 CHAPTER 557. INSURED PROPERTY SUBJECT TO SECURITY INTEREST

21 SUBCHAPTER A. INSURANCE PROCEEDS HELD BY LENDER PENDING

22 REPAIR OF RESIDENTIAL REAL PROPERTY

23 Revised Law

24 Sec. 557.001. DEFINITIONS. In this subchapter:

25 (1) "Lender" means a person holding a mortgage, lien,
26 deed of trust, or other security interest in property.

27 (2) "Residential real property" means:

28 (A) a single-family house;

29 (B) a duplex, triplex, or quadraplex; or

30 (C) a unit in a multi-unit residential structure
31 in which title to an individual unit is transferred to the owner of
32 the unit under a condominium or cooperative system. (V.T.I.C. Art.
33 21.48B, Sec. 1.)

1 Source Law

2 Art. 21.48B

3 Sec. 1. In this article:

4 (1) "Lender" means a person holding a
5 mortgage, lien, deed of trust, or other security
6 interest in property.

7 (2) "Residential real property" means a
8 single-family house, a duplex, triplex, or quadraplex,
9 or a unit in a multi-unit residential structure in
10 which title to an individual unit is transferred to the
11 owner of the unit under a condominium or cooperative
12 system.

13 Revised Law

14 Sec. 557.002. NOTIFICATION BY LENDER TO INSURED CONCERNING
15 INSURANCE PROCEEDS. (a) If a claim under an insurance policy for
16 damage to residential real property is paid to the insured and a
17 lender, and the lender holds all or part of the proceeds from the
18 insurance claim payment pending completion of all or part of the
19 repairs to the property, the lender shall notify the insured of each
20 requirement with which the insured must comply for the lender to
21 release the insurance proceeds.

22 (b) The notice required under this section must be provided
23 not later than the 10th day after the date the lender receives
24 payment of the insurance proceeds. (V.T.I.C. Art. 21.48B, Sec.
25 2(a).)

26 Source Law

27 Sec. 2. (a) If a claim under an insurance
28 policy for damage to residential real property is paid
29 to the insured and a lender holding a security interest
30 in the property, and the lender holds all or part of
31 the insurance claim payment pending completion of all
32 or part of the repairs, the lender not later than the
33 10th day after the date the payment of the insurance
34 proceeds is received shall notify the insured of the
35 requirements that the insured must satisfy before the
36 lender releases the insurance proceeds.

37 Revisor's Note

38 Section 2(a), V.T.I.C. Article 21.48B, refers to
39 a lender "holding a security interest in the
40 property." The revised law omits the quoted language
41 as unnecessary because Section 1(1), V.T.I.C. Article
42 21.48B, revised as Section 557.001(1), defines
43 "lender" as a person holding a "security interest in
44 property."

1 Revised Law

2 Sec. 557.003. LENDER'S RELEASE OR REFUSAL TO RELEASE
3 INSURANCE PROCEEDS. Not later than the 10th day after the date a
4 lender receives from the insured a request for release of all or
5 part of the insurance proceeds held by the lender, the lender shall:

6 (1) if the lender has received sufficient evidence of
7 the insured's compliance with the requirements specified by the
8 lender under Section 557.002 for release of the proceeds, release
9 to the insured, as requested, all or part of the proceeds; or

10 (2) provide notice to the insured that explains
11 specifically:

12 (A) the reason for the lender's refusal to
13 release the proceeds to the insured; and

14 (B) each requirement with which the insured must
15 comply for the lender to release the proceeds. (V.T.I.C. Art.
16 21.48B, Sec. 2(b).)

17 Source Law

18 (b) Not later than the 10th day after the date
19 the insured's request for payment of all or part of the
20 insurance proceeds is received by the lender, the
21 lender shall:

22 (1) pay to the insured, if the lender has
23 received sufficient evidence of compliance with the
24 requirements and conditions for release of the funds
25 as specified in Subsection (a) of this section, all or
26 part of the proceeds held by the lender, as requested;
27 or

28 (2) explain, in specific detail, the
29 reason for the lender's refusal to pay the proceeds to
30 the insured and the requirements the insured must
31 satisfy before the lender releases the insurance
32 proceeds.

33 Revisor's Note

34 (1) Section 2(b), V.T.I.C. Article 21.48B,
35 refers to compliance with "requirements and
36 conditions." Throughout this subchapter, the revised
37 law omits as unnecessary the reference to "conditions"
38 when a reference is made to "requirements and
39 conditions" because, in context, "conditions" is
40 included within the meaning of "requirements."

41 (2) Section 2(b), V.T.I.C. Article 21.48B,

1 requires a lender to provide an explanation in
2 "specific detail." The revised law omits as
3 unnecessary the reference to "detail" because, in
4 context, "detail" is included within the meaning of
5 "specific."

6 Revised Law

7 Sec. 557.004. PAYMENT OF INTEREST; RATE. A lender who
8 fails to provide notice as required by Section 557.002 or 557.003 or
9 to release insurance proceeds as required by Section 557.003 shall
10 pay to the insured interest at the rate of 10 percent a year on the
11 proceeds held by the lender. (V.T.I.C. Art. 21.48B, Sec. 3(a).)

12 Source Law

13 Sec. 3. (a) If the lender fails to give the
14 notice required under Section 2(a) or (b)(2) of this
15 article or fails to make a payment within the time
16 required by Section 2(b)(1) of this article, the
17 lender shall pay to the insured interest on the money
18 held at the rate of 10 percent a year.

19 Revised Law

20 Sec. 557.005. ACCRUAL OF INTEREST. (a) If a lender fails
21 to provide notice as required by Section 557.002 or 557.003,
22 interest begins to accrue on the date the lender received the
23 insurance proceeds.

24 (b) If a lender fails to release insurance proceeds as
25 required by Section 557.003, interest begins to accrue on the date
26 the lender receives sufficient evidence of the insured's compliance
27 with the requirements specified by the lender under Section 557.002
28 or 557.003 for release of the proceeds.

29 (c) Interest stops accruing on the date the lender complies
30 with Section 557.002 or 557.003, as applicable. (V.T.I.C. Art.
31 21.48B, Secs. 3(b), (c).)

32 Source Law

33 (b) If the lender fails to give the notice
34 required under Section 2(a) or (b)(2) of this article,
35 the interest begins to accrue on the date the lender
36 receives the insurance proceeds. If the lender fails
37 to make a payment within the time required by Section
38 2(b)(1) of this article, the interest begins to accrue
39 on the date the lender receives satisfactory evidence
40 of compliance with the requirements and conditions for

1 release of the funds as specified in Section 2(a) or
2 2(b)(1) of this article.

3 (c) Interest terminates on the date the lender
4 complies with Section 2 of this article.

5 Revisor's Note

6 Section 3(b), V.T.I.C. Article 21.48B, provides
7 that if a lender fails to release insurance proceeds to
8 an insured as required by Section 2(b)(1) of that
9 article, interest begins to accrue on the date the
10 lender receives "satisfactory evidence" of the
11 insured's compliance with the requirements specified
12 for release of the funds. Section 2(b)(1), revised as
13 Section 557.003(1), requires a lender to release
14 insurance proceeds to an insured if the lender
15 receives "sufficient evidence" of the insured's
16 compliance with the requirements specified for release
17 of the funds. For consistency, the revised law
18 substitutes "sufficient evidence" for the reference to
19 "satisfactory evidence" in Section 3(b), V.T.I.C.
20 Article 21.48B.

21 Revised Law

22 Sec. 557.006. INTEREST NOT REQUIRED ON INSURANCE PROCEEDS
23 APPLIED TO REDUCE NOTE. A lender is not required to pay interest on
24 insurance proceeds applied, in accordance with the terms and
25 conditions of a deed of trust or other security agreement, to reduce
26 a note. (V.T.I.C. Art. 21.48B, Sec. 3(d).)

27 Source Law

28 (d) A lender is not required to pay interest on
29 money applied, in accordance with the terms and
30 conditions of a deed of trust or other security
31 agreement, to reduce the note.

32 Revisor's Note

33 Section 3(d), V.T.I.C. Article 21.48B, provides
34 that a lender is not required to pay interest on
35 "money" applied to reduce a note. The revised law
36 substitutes "insurance proceeds" for "money" because,
37 in context, it is clear that "money" means "insurance

1 proceeds" and using "insurance proceeds" is consistent
2 with the terminology used in this chapter.

3 [Sections 557.007-557.050 reserved for expansion]

4 SUBCHAPTER B. LIENHOLDER APPROVAL OF INSURANCE CLAIM

5 PAYMENT RELATING TO PERSONAL PROPERTY

6 Revised Law

7 Sec. 557.051. LIENHOLDER APPROVAL OF PAYMENT. If payment
8 of an insurance claim relating to personal property requires the
9 endorsement of a check or draft by a holder of a lien on the property
10 or otherwise requires approval of the lienholder, not later than
11 the 14th business day after the date the lienholder receives a
12 request for the endorsement or other approval, the lienholder shall
13 provide:

14 (1) the endorsement or approval; or

15 (2) a written statement of the reason for denial of the
16 endorsement or approval to the person who requested the endorsement
17 or approval. (V.A.C.S. Art. 9031, Sec. 1.)

18 Source Law

19 Art. 9031

20 Sec. 1. If payment of an insurance claim
21 relating to personal property requires the endorsement
22 of a check or draft by a holder of a lien on the
23 property or otherwise requires approval of the
24 lienholder, the lienholder, not later than the 14th
25 business day after the date the lienholder receives a
26 request for the endorsement or other approval, shall:

27 (1) provide the endorsement or other
28 approval; or

29 (2) provide the person who requested the
30 endorsement or other approval a written statement of
31 the reason for denial of the endorsement or other
32 approval.

33 Revised Law

34 Sec. 557.052. CIVIL PENALTY. (a) A lienholder who
35 violates Section 557.051 is liable for a civil penalty not to exceed
36 \$500 for each violation.

37 (b) The attorney general may bring an action to collect a
38 civil penalty under this section. (V.A.C.S. Art. 9031, Sec. 2.)

39 Source Law

40 Sec. 2. (a) A lienholder who violates Section 1
41 of this article is liable for a civil penalty not to

1 exceed \$500 for each violation.

2 (b) The attorney general may sue to collect a
3 civil penalty under this section.

4 CHAPTER 558. REFUND OF UNEARNED PREMIUM

5 Sec. 558.001. DEFINITION. 445
6 Sec. 558.002. APPLICABILITY OF CHAPTER; REFUND OF UNEARNED
7 PREMIUM 447
8 Sec. 558.003. RULES AND GUIDELINES 448
9 Sec. 558.004. EFFECT ON INSURANCE PREMIUM FINANCE COMPANY . . 448

10 CHAPTER 558. REFUND OF UNEARNED PREMIUM

11 Revised Law

12 Sec. 558.001. DEFINITION. In this chapter, "insurer"
13 means an insurance company or other entity authorized to engage in
14 the business of insurance in this state. The term includes:

- 15 (1) a stock life, health, or accident insurance
16 company;
17 (2) a mutual life, health, or accident insurance
18 company;
19 (3) a stock fire or casualty insurance company;
20 (4) a mutual fire or casualty insurance company;
21 (5) a Mexican casualty insurance company;
22 (6) a farm mutual insurance company;
23 (7) a county mutual insurance company;
24 (8) a Lloyd's plan;
25 (9) a reciprocal or insurance exchange;
26 (10) a fraternal benefit society;
27 (11) a stipulated premium company;
28 (12) a nonprofit legal services corporation;
29 (13) a statewide mutual assessment company;
30 (14) a local mutual aid association;
31 (15) a local mutual burial association;
32 (16) an association exempt under Section 887.102;
33 (17) a nonprofit hospital, medical, or dental service
34 corporation, including a corporation subject to Chapter 842;
35 (18) a risk retention group;

- 1 (19) a purchasing group;
2 (20) an eligible surplus lines insurer; and
3 (21) a guaranty association operating under Article
4 21.28-C or 21.28-D. (V.T.I.C. Art. 21.29, Sec. (a).)

5 Source Law

6 Art. 21.29. (a) In this article, "insurer"
7 means an insurance company or other entity that is
8 authorized to engage in the business of insurance in
9 this state, including:

- 10 (1) a domestic or foreign, stock or
11 mutual, life, health, or accident insurance company;
12 (2) a domestic or foreign, stock or
13 mutual, fire and casualty insurance company;
14 (3) a Mexican casualty company;
15 (4) a farm mutual insurance company;
16 (5) a county mutual insurance company;
17 (6) a domestic or foreign Lloyd's plan
18 insurer;
19 (7) a domestic or foreign reciprocal or
20 insurance exchange;
21 (8) a domestic or foreign fraternal
22 benefit society;
23 (9) a stipulated premium insurance
24 company;
25 (10) a nonprofit legal service
26 corporation;
27 (11) a statewide mutual assessment
28 company;
29 (12) a local mutual aid association;
30 (13) a local mutual burial association;
31 (14) an association exempt under Article
32 14.17 of this code;
33 (15) a nonprofit hospital, medical, or
34 dental service corporation, including a company
35 subject to Chapter 20 of this code;
36 (16) a risk retention group;
37 (17) a purchase group;
38 (18) a surplus lines carrier; and
39 (19) a guaranty association created and
40 operating under Article 21.28-C or 21.28-D of this
41 code.

42 Revisor's Note

43 (1) Section (a), V.T.I.C. Article 21.29,
44 provides that "insurer" means an insurance company or
45 other entity that is authorized to engage in the
46 business of insurance in this state, including certain
47 "domestic or foreign" insurers. The revised law omits
48 the references to "domestic or foreign" as
49 unnecessary. Because the revised law applies to all
50 insurers authorized to engage in the business of
51 insurance in this state, it is not necessary to

1 distinguish between domestic and foreign insurers in
2 this section.

3 (2) Section (a)(17), V.T.I.C. Article 21.29,
4 refers to a "purchase group." The revised law
5 substitutes "purchasing group" for "purchase group"
6 because that is the term used in V.T.I.C. Article
7 21.54, which regulates risk retention groups and
8 purchasing groups.

9 (3) Section (a)(18), V.T.I.C. Article 21.29,
10 refers to a "surplus lines carrier." The revised law
11 substitutes "eligible surplus lines insurer" for
12 "surplus lines carrier" because that is the term used
13 in Chapter 981 of this code, which regulates surplus
14 lines insurance.

15 Revised Law

16 Sec. 558.002. APPLICABILITY OF CHAPTER; REFUND OF UNEARNED
17 PREMIUM. (a) This chapter applies to an insurer that issues an
18 insurance policy that requires the insurer to maintain an unearned
19 premium reserve for the portion of the written policy premium
20 applicable to the unexpired or unused part of the policy period for
21 which the premium has been paid.

22 (b) An insurer shall promptly refund the appropriate
23 portion of any unearned premium to the policyholder if the policy:

24 (1) has a remaining unearned premium reserve; and

25 (2) is canceled or terminated by the insured or the
26 insurer before the end of its term.

27 (c) A guaranty association shall promptly refund any
28 unearned premium as described by Section 5(8), Article 21.28-C, or
29 Sections 5(10) and 8(n), Article 21.28-D. (V.T.I.C. Art. 21.29,
30 Secs. (b), (c).)

31 Source Law

32 (b) If an insurer issues a policy of insurance
33 that requires the insurer to maintain an unearned
34 premium reserve for the portion of the written policy
35 premium applicable to the unexpired or unused part of
36 the policy period for which the premium has been paid

1 and the policy is canceled or terminated by the insured
2 or the insurer before the end of the policy term with a
3 remaining unearned premium reserve on the policy, the
4 insurer shall promptly refund to the policyholder the
5 appropriate portion of the unearned premium.

6 (c) A guaranty association shall promptly
7 refund any unearned premium defined in Section 5(8),
8 Article 21.28-C, and Section 5(10), Article 21.28-D.

9 Revisor's Note

10 Section (c), V.T.I.C. Article 21.29, refers to
11 "any unearned premium defined in Section 5(8), Article
12 21.28-C, and Section 5(10), Article 21.28-D." Neither
13 Section 5(8), V.T.I.C. Article 21.28-C, nor Section
14 5(10), V.T.I.C. Article 21.28-D, defines the term
15 "unearned premium." The revised law refers to any
16 unearned premium as described by Section 5(8), Article
17 21.28-C, because the term is described in the
18 definition of "covered claim" provided by that
19 section. The revised law also refers to any unearned
20 premium as described by Sections 5(10) and 8(n),
21 Article 21.28-D, because Section 8(n) is the only
22 provision in that article that refers to unearned
23 premiums and Section 5(10) defines "premiums" for
24 purposes of that article.

25 Revised Law

26 Sec. 558.003. RULES AND GUIDELINES. The commissioner
27 shall:

28 (1) adopt rules necessary to implement this chapter;

29 and

30 (2) establish appropriate guidelines to determine the
31 portion of an unearned premium that must be refunded to a
32 policyholder under this chapter. (V.T.I.C. Art. 21.29, Sec. (d).)

33 Source Law

34 (d) The commissioner shall adopt rules
35 necessary to implement this article and provide
36 appropriate guidelines for determining the portion of
37 an unearned premium that must be refunded to a
38 policyholder under this article.

39 Revised Law

40 Sec. 558.004. EFFECT ON INSURANCE PREMIUM FINANCE

1 COMPANY. This chapter does not affect the obligation of an insurer
2 to pay an unearned premium to an insurance premium finance company
3 in accordance with Section 651.162. (V.T.I.C. Art. 21.29, Sec.
4 (e).)

5 Source Law

6 (e) Nothing in this article affects the
7 obligation of an insurer to pay an unearned premium to
8 a premium finance company in accordance with Article
9 24.17(f) of this code.

10 [Chapters 559-600 reserved for expansion]

11 SUBTITLE D. PRIVACY

12 CHAPTER 601. PRIVACY

13 SUBCHAPTER A. GENERAL PROVISIONS

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17 Sec. 601.004. TREATMENT OF CERTAIN HEALTH INFORMATION;
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19 [Sections 601.005-601.050 reserved for expansion]

20 SUBCHAPTER B. DEPARTMENT POWERS AND DUTIES

21 Sec. 601.051. RULES 451
22 Sec. 601.052. IMPLEMENTATION OF CERTAIN STANDARDS 452

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24 SUBCHAPTER C. ENFORCEMENT

25 Sec. 601.101. ENFORCEMENT BY DEPARTMENT 452
26 Sec. 601.102. INJUNCTIVE OR DECLARATORY RELIEF; CIVIL
27 PENALTY 453

28 CHAPTER 601. PRIVACY

29 SUBCHAPTER A. GENERAL PROVISIONS

30 Revised Law

31 Sec. 601.001. DEFINITIONS. In this chapter:

32 (1) "Affiliate" means a company that controls, is
33 controlled by, or is under common control with another company. For
34 the purposes of this subdivision, "control" has the meaning
35 described by Sections 823.005 and 823.151.

1 (2) "Authorization" has the meaning assigned by
2 Section 82.001.

3 (3) "Covered entity" means an individual or entity
4 that receives an authorization from the department. The term
5 includes an individual or entity described by Section 82.002.

6 (4) "Nonaffiliated third party" means an entity that
7 is not an affiliate of, or related to by common ownership or
8 affiliated by corporate control with, the covered entity. The term
9 does not include a joint employee of the entity. (V.T.I.C. Art.
10 28A.01.)

11 Source Law

12 Art. 28A.01. In this chapter:

13 (1) "Affiliate" means any company that
14 controls, is controlled by, or is under common control
15 with another company; and the term "control,"
16 including the terms "controls," "controlled by," and
17 "under common control," has the meaning assigned that
18 term by Section 2(d), Article 21.49-1, of this code.

19 (2) "Authorization" has the meaning
20 assigned by Section 82.001 of this code.

21 (3) "Covered entity" means an individual
22 or entity who receives an authorization from the
23 department. The term includes any individual or
24 entity described by Section 82.002 of this code.

25 (4) "Nonaffiliated third party" means an
26 entity that is not an affiliate of, or related to by
27 common ownership or affiliated by corporate control
28 with, the covered entity. The term does not include a
29 joint employee of the entity.

30 Revised Law

31 Sec. 601.002. COMPLIANCE WITH FEDERAL LAW REQUIRED. (a) A
32 covered entity shall comply with 15 U.S.C. Sections 6802 and 6803,
33 as amended, in the same manner as a financial institution is
34 required to comply under those sections.

35 (b) An entity that is a nonaffiliated third party in
36 relation to a covered entity shall comply with 15 U.S.C. Section
37 6802(c), as amended. (V.T.I.C. Art. 28A.02.)

38 Source Law

39 Art. 28A.02. (a) A covered entity shall comply
40 with 15 U.S.C. Sections 6802 and 6803, as amended, in
41 the same manner as a financial institution under those
42 sections.

43 (b) An entity that is a nonaffiliated third
44 party in relation to a covered entity shall comply with
45 15 U.S.C. Section 6802(c), as amended.

1 Revised Law

2 Sec. 601.003. EXEMPTION. Section 601.002(a) does not
3 apply to a covered entity to the extent that the entity is acting
4 solely as an insurance agent, employee, or other authorized
5 representative for another covered entity. (V.T.I.C. Art. 28A.03.)

6 Source Law

7 Art. 28A.03. Article 28A.02(a) of this code does
8 not apply to a covered entity to the extent that the
9 entity is acting solely as the insurance agent,
10 employee, or other authorized representative for
11 another covered entity.

12 Revised Law

13 Sec. 601.004. TREATMENT OF CERTAIN HEALTH INFORMATION;
14 STRICTER RULES NOT PRECLUDED. This chapter does not affect the
15 authority of the department or another state agency to adopt
16 stricter rules governing the treatment of health information by a
17 covered entity if another law gives the department or agency that
18 authority, including a law or rule of this state related to the
19 privacy of individually identifiable health information under
20 Subtitle F, Title II, Health Insurance Portability and
21 Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.), as
22 amended. (V.T.I.C. Art. 28A.04.)

23 Source Law

24 Art. 28A.04. This chapter does not affect the
25 authority of the department or another state agency to
26 adopt stricter rules governing the treatment of health
27 information by a covered entity, if another law gives
28 the department or agency that authority, including any
29 laws or rules of this state related to the privacy of
30 individually identifiable health information under
31 the federal Health Insurance Portability and
32 Accountability Act of 1996 (42 U.S.C. Section 1320d et
33 seq.), as amended.

34 [Sections 601.005-601.050 reserved for expansion]

35 SUBCHAPTER B. DEPARTMENT POWERS AND DUTIES

36 Revised Law

37 Sec. 601.051. RULES. (a) The commissioner shall adopt:
38 (1) rules to implement this chapter; and
39 (2) any other rules necessary to carry out Subtitle A,
40 Title V, Gramm-Leach-Bliley Act (15 U.S.C. Section 6801 et seq.),

1 as amended, to make this state eligible to override federal
2 regulations as described by 15 U.S.C. Section 6805(c), as amended.

3 (b) In adopting rules under this chapter, the commissioner
4 shall attempt to keep state privacy requirements consistent with
5 federal regulations adopted under Subtitle A, Title V,
6 Gramm-Leach-Bliley Act (15 U.S.C. Section 6801 et seq.), as
7 amended. (V.T.I.C. Art. 28A.51.)

8 Source Law

9 Art. 28A.51. (a) The commissioner shall adopt
10 rules to implement this chapter.

11 (b) The commissioner shall adopt any other rules
12 necessary to carry out 15 U.S.C. Subchapter I, Chapter
13 94 (15 U.S.C. Section 6801 et seq.), as amended, to
14 make this state eligible to override federal
15 regulations, as described by 15 U.S.C. Section
16 6805(c), as amended.

17 (c) In adopting rules under this chapter, the
18 commissioner shall attempt to keep state privacy
19 requirements consistent with federal regulations
20 adopted under 15 U.S.C. Subchapter I, Chapter 94 (15
21 U.S.C. Section 6801 et seq.), as amended.

22 Revised Law

23 Sec. 601.052. IMPLEMENTATION OF CERTAIN STANDARDS. The
24 department shall implement standards as required by 15 U.S.C.
25 Section 6805(b), as amended. (V.T.I.C. Art. 28A.52.)

26 Source Law

27 Art. 28A.52. The department shall implement
28 standards as required by 15 U.S.C. Section 6805(b), as
29 amended.

30 [Sections 601.053-601.100 reserved for expansion]

31 SUBCHAPTER C. ENFORCEMENT

32 Revised Law

33 Sec. 601.101. ENFORCEMENT BY DEPARTMENT. The department
34 shall enforce 15 U.S.C. Sections 6801-6805, as amended, to the
35 extent required by 15 U.S.C. Section 6805, as amended, and this
36 chapter. (V.T.I.C. Art. 28A.101.)

37 Source Law

38 Art. 28A.101. The department shall enforce 15
39 U.S.C. Sections 6801-6805, as amended, to the extent
40 required by 15 U.S.C. Section 6805, as amended, and
41 this chapter.

1 Revised Law

2 Sec. 601.102. INJUNCTIVE OR DECLARATORY RELIEF; CIVIL
3 PENALTY. (a) The attorney general, after conferring with the
4 commissioner, may institute an action for injunctive or declaratory
5 relief to restrain a violation of this chapter.

6 (b) In addition to instituting an action for injunctive
7 relief under Subsection (a), the attorney general, after conferring
8 with the commissioner, may institute an action for civil penalties
9 against a covered entity or nonaffiliated third party for a
10 violation of this chapter. A civil penalty assessed under this
11 section may not exceed \$3,000 for each violation.

12 (c) If the court in which an action under Subsection (b) is
13 pending finds that violations of this chapter have occurred with a
14 frequency that constitutes a pattern or practice, the court may
15 assess a civil penalty not to exceed \$250,000.

16 (d) If the attorney general substantially prevails in an
17 action for injunctive relief or a civil penalty under this section,
18 the attorney general may recover reasonable attorney's fees, costs,
19 and expenses incurred obtaining the relief or penalty, including
20 court costs and witness fees. (V.T.I.C. Art. 28A.102.)

21 Source Law

22 Art. 28A.102. (a) The attorney general, after
23 conferring with the commissioner, may institute an
24 action for injunctive or declaratory relief to
25 restrain a violation of this chapter.

26 (b) In addition to the injunctive relief
27 provided by Subsection (a) of this article, the
28 attorney general, after conferring with the
29 commissioner, may institute an action for civil
30 penalties against a covered entity or a nonaffiliated
31 third party for a violation of this chapter. A civil
32 penalty assessed under this article may not exceed
33 \$3,000 for each violation.

34 (c) If the court in which an action under
35 Subsection (b) of this article is pending finds that
36 the violations have occurred with a frequency as to
37 constitute a pattern or practice, the court may assess
38 a civil penalty not to exceed \$250,000.

39 (d) If the attorney general substantially
40 prevails in an action for injunctive relief or a civil
41 penalty under this article, the attorney general may
42 recover reasonable attorney's fees, costs, and
43 expenses incurred obtaining the relief or penalty,
44 including court costs and witness fees.

1 CHAPTER 602. PRIVACY OF HEALTH INFORMATION

2 SUBCHAPTER A. GENERAL PROVISIONS

3 Sec. 602.001. DEFINITIONS 454

4 Sec. 602.002. APPLICABILITY OF CHAPTER TO COVERED ENTITY

5 REQUIRED TO COMPLY WITH CERTAIN

6 FEDERAL STANDARDS 456

7 Sec. 602.003. CONSTRUCTION OF CHAPTER 457

8 Sec. 602.004. RULES 457

9 [Sections 602.005-602.050 reserved for expansion]

10 SUBCHAPTER B. AUTHORIZED DISCLOSURE OF CERTAIN

11 HEALTH INFORMATION

12 Sec. 602.051. AUTHORIZATION FOR DISCLOSURE OF CERTAIN HEALTH

13 INFORMATION 458

14 Sec. 602.052. DELIVERY OF AUTHORIZATION FORM AND REQUEST FOR

15 AUTHORIZATION 460

16 Sec. 602.053. EXCEPTIONS 460

17 [Sections 602.054-602.100 reserved for expansion]

18 SUBCHAPTER C. PENALTIES AND ENFORCEMENT

19 Sec. 602.101. PROHIBITION 464

20 Sec. 602.102. INJUNCTION 464

21 Sec. 602.103. CIVIL PENALTY 464

22 Sec. 602.104. DISCIPLINARY ACTION 465

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24 Sec. 602.106. REMEDIES AVAILABLE 465

25 CHAPTER 602. PRIVACY OF HEALTH INFORMATION

26 SUBCHAPTER A. GENERAL PROVISIONS

27 Revised Law

28 Sec. 602.001. DEFINITIONS. In this chapter:

29 (1) "Covered entity" means a person who holds or is

30 required to hold a license, registration, certificate of authority,

31 or other authorization under this code or another insurance law of

32 this state. The term includes:

33 (A) an insurance company, including:

34 (i) a county mutual insurance company;

- 1 (ii) a farm mutual insurance company;
2 (iii) a fraternal benefit society;
3 (iv) a group hospital service corporation;
4 (v) a Lloyd's plan;
5 (vi) a local mutual aid association;
6 (vii) a mutual insurance company;
7 (viii) a reciprocal or interinsurance
8 exchange;
9 (ix) a statewide mutual assessment company;
10 and
11 (x) a stipulated premium company;
12 (B) a health maintenance organization; and
13 (C) an insurance agent.

14 (2) "Health information" means information regarding
15 an individual, other than the individual's age or gender, whether
16 provided orally or recorded in any medium or form, that is created
17 by or derived from the individual or a health care provider and that
18 relates to:

- 19 (A) the past, present, or future physical,
20 mental, or behavioral health or condition of the individual;
21 (B) the provision of health care to the
22 individual; or
23 (C) payment for the provision of health care to
24 the individual.

25 (3) "Nonpublic personal health information" means
26 health information:

- 27 (A) that identifies an individual who is the
28 subject of the information; or
29 (B) with respect to which there is a reasonable
30 basis to believe that the information could be used to identify an
31 individual. (V.T.I.C. Art. 28B.01.)

32 Source Law

33 Art. 28B.01. In this chapter:

- 34 (1) "Health information" means any
35 information or data regarding an individual, other

1 than age or gender, whether oral or recorded in any
2 form or medium, that is created by or derived from a
3 health care provider or the individual and that
4 relates to:

5 (A) the past, present, or future
6 physical, mental, or behavioral health or condition of
7 an individual;

8 (B) the provision of health care to
9 an individual; or

10 (C) payment for the provision of
11 health care to an individual.

12 (2) "Licensee" means a person who holds or
13 is required to hold a license, registration,
14 certificate of authority, or other authority under
15 this code or another insurance law of this state. The
16 term includes an insurance company, group hospital
17 service corporation, mutual insurance company, local
18 mutual aid association, statewide mutual assessment
19 company, stipulated premium insurance company, health
20 maintenance organization, reciprocal or
21 interinsurance exchange, Lloyd's plan, fraternal
22 benefit society, county mutual insurer, farm mutual
23 insurer, or insurance agent.

24 (3) "Nonpublic personal health
25 information" means health information:

26 (A) that identifies an individual who
27 is the subject of the information; or

28 (B) with respect to which there is a
29 reasonable basis to believe that the information could
30 be used to identify an individual.

31 Revisor's Note

32 (1) Subdivision (1), V.T.I.C. Article 28B.01,
33 refers to "information or data." The revised law omits
34 "data" because "data" is included in the meaning of
35 "information."

36 (2) Subdivision (2), V.T.I.C. Article 28B.01,
37 defines "licensee" as a person who holds a "license,
38 registration, certificate of authority, or other
39 authority." Since the definition includes persons who
40 hold authorizations other than a license, the revised
41 law substitutes "covered entity" as the defined term.
42 Furthermore, since V.T.I.C. Article 28B.09(b),
43 revised as Section 602.103, refers to a "covered
44 entity," the use of that term throughout this chapter
45 ensures consistency of terminology in this chapter, as
46 well as throughout this code.

47 Revised Law

48 Sec. 602.002. APPLICABILITY OF CHAPTER TO COVERED ENTITY
49 REQUIRED TO COMPLY WITH CERTAIN FEDERAL STANDARDS. This chapter

1 does not apply to a covered entity that is required to comply with
2 the standards governing the privacy of individually identifiable
3 health information adopted by the United States secretary of health
4 and human services under Section 262(a), Health Insurance
5 Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d
6 et seq.). (V.T.I.C. Art. 28B.05.)

7 Source Law

8 Art. 28B.05. This subchapter does not apply to a
9 licensee who is required to comply with the standards
10 governing the privacy of individually identifiable
11 health information adopted by the United States
12 Secretary of Health and Human Services under Section
13 262(a), Health Insurance Portability and
14 Accountability Act of 1996 (42 U.S.C. Sections
15 1320d-1320d-8).

16 Revised Law

17 Sec. 602.003. CONSTRUCTION OF CHAPTER. (a) This chapter
18 does not preempt or supersede state law in effect on July 1, 2002,
19 that relates to the privacy of medical records, health information,
20 or insurance information.

21 (b) This chapter may not be construed to modify, limit, or
22 supersede the operation of the federal Fair Credit Reporting Act
23 (15 U.S.C. Section 1681 et seq.).

24 (c) This chapter may not be used as a basis for drawing an
25 inference that information is or is not transaction or experience
26 information under Section 603 of the federal Fair Credit Reporting
27 Act (15 U.S.C. Section 1681a). (V.T.I.C. Art. 28B.06.)

28 Source Law

29 Art. 28B.06. (a) This chapter may not be
30 construed to modify, limit, or supersede the operation
31 of the Fair Credit Reporting Act (15 U.S.C. Section
32 1681 et seq.) and an inference may not be drawn based
33 on this chapter regarding whether information is
34 transaction or experience information under Section
35 603 of that Act (15 U.S.C. Section 1681a).

36 (b) This chapter does not preempt or supersede a
37 state law related to medical record, health, or
38 insurance information privacy that is in effect on
39 July 1, 2002.

40 Revised Law

41 Sec. 602.004. RULES. The commissioner may adopt rules as
42 necessary to implement this chapter. (V.T.I.C. Art. 28B.08.)

1 Source Law

2 Art. 28B.08. The commissioner may adopt rules as
3 necessary to implement this chapter.

4 [Sections 602.005-602.050 reserved for expansion]

5 SUBCHAPTER B. AUTHORIZED DISCLOSURE OF CERTAIN
6 HEALTH INFORMATION

7 Revised Law

8 Sec. 602.051. AUTHORIZATION FOR DISCLOSURE OF CERTAIN
9 HEALTH INFORMATION. (a) Except as provided by Section 602.053, a
10 covered entity must obtain authorization to disclose nonpublic
11 personal health information before disclosing the information.

12 (b) A request for authorization to disclose nonpublic
13 personal health information may be in written or electronic form
14 and must:

15 (1) state the identity of the consumer or customer who
16 is the subject of the information;

17 (2) describe:

18 (A) each type of information to be disclosed;

19 (B) each party to whom the covered entity intends
20 to disclose the information;

21 (C) the purpose of the disclosure;

22 (D) how the information will be used; and

23 (E) the procedure for revoking the
24 authorization;

25 (3) include the signature of:

26 (A) the consumer or customer who is the subject
27 of the information; or

28 (B) the individual who is legally empowered to
29 grant authorization;

30 (4) state the date the authorization is signed; and

31 (5) provide notice of:

32 (A) the period for which the authorization is
33 valid; and

34 (B) the consumer's or customer's right to revoke
35 the authorization at any time.

1 (c) The period for which the authorization is valid may not
2 exceed 24 months.

3 (d) The right of a consumer or customer to revoke an
4 authorization at any time is subject to the rights of an individual
5 who, before receiving notice of a revocation, acted in reliance on
6 the authorization.

7 (e) The covered entity shall retain the original or a copy
8 of the authorization in the records of the individual who is the
9 subject of the nonpublic personal health information. (V.T.I.C.
10 Art. 28B.02.)

11 Source Law

12 Art. 28B.02. (a) A licensee must obtain an
13 authorization to disclose any nonpublic personal
14 health information before making such a disclosure.

15 (b) The request for authorization required by
16 this article may be in written or electronic form and
17 must:

18 (1) state the identity of the consumer or
19 customer who is the subject of the nonpublic personal
20 health information;

21 (2) describe:

22 (A) the types of nonpublic personal
23 health information to be disclosed;

24 (B) the parties to whom the licensee
25 discloses nonpublic personal health information;

26 (C) the purpose of the disclosure;

27 (D) how the information will be used;
28 and

29 (E) the procedure for revoking the
30 authorization;

31 (3) include the signature and date signed
32 of:

33 (A) the consumer or customer who is
34 the subject of the nonpublic personal health
35 information; or

36 (B) the individual who is legally
37 empowered to grant authority;

38 (4) provide notice:

39 (A) of the length of time for which
40 the authorization is valid; and

41 (B) that the consumer or customer may
42 revoke the authorization at any time; and

43 (5) specify the amount of time that the
44 authorization remains valid, which may not exceed 24
45 months.

46 (c) The right of a consumer or customer to
47 revoke an authorization at any time is subject to the
48 rights of an individual who acted in reliance on the
49 authorization before receiving notice of a revocation.

50 (d) The licensee shall retain the original or a
51 copy of the authorization in the record of the
52 individual who is the subject of the nonpublic
53 personal health information.

1 Revisor's Note

2 V.T.I.C. Article 28B.02(b)(4) provides that a
3 request for authorization to disclose nonpublic
4 personal health information must "provide
5 notice . . . of the length of time for which the
6 authorization is valid." Subsection (b)(5) of that
7 article provides that the request must "specify the
8 amount of time that the authorization remains valid."
9 The separately stated requirements are substantively
10 the same. The revised law substitutes for those
11 requirements a provision that the request "must . . .
12 provide notice of . . . the period for which the
13 authorization is valid."

14 Revised Law

15 Sec. 602.052. DELIVERY OF AUTHORIZATION FORM AND REQUEST
16 FOR AUTHORIZATION. (a) A covered entity may deliver to a consumer
17 or customer a request for authorization and an authorization form
18 only if the request and form are clear and conspicuous.

19 (b) A covered entity is required to include delivery of the
20 authorization form in a notice to a consumer or customer only if the
21 covered entity intends to disclose health information protected
22 under this chapter. (V.T.I.C. Art. 28B.03.)

23 Source Law

24 Art. 28B.03. (a) A request for authorization
25 and an authorization form may be delivered to a
26 consumer or a customer if the request and the
27 authorization form are clear and conspicuous.

28 (b) A licensee must include delivery of the
29 authorization in a notice to the consumer or customer
30 only if the licensee intends to disclose protected
31 health information under this chapter.

32 Revised Law

33 Sec. 602.053. EXCEPTIONS. A covered entity may disclose
34 nonpublic personal health information to the extent that the
35 disclosure is necessary to perform the following insurance or
36 health maintenance organization functions on behalf of the covered
37 entity:

- 1 (1) the investigation or reporting of actual or
- 2 potential fraud, misrepresentation, or criminal activity;
- 3 (2) underwriting;
- 4 (3) the placement or issuance of an insurance policy
- 5 or evidence of coverage;
- 6 (4) loss control services;
- 7 (5) ratemaking or guaranty fund functions;
- 8 (6) reinsurance or excess loss insurance;
- 9 (7) risk management;
- 10 (8) case management;
- 11 (9) disease management;
- 12 (10) quality assurance;
- 13 (11) quality improvement;
- 14 (12) performance evaluation;
- 15 (13) health care provider credentialing verification;
- 16 (14) utilization review;
- 17 (15) peer review activities;
- 18 (16) actuarial, scientific, medical, or public policy
- 19 research;
- 20 (17) grievance procedures;
- 21 (18) the internal administration of compliance,
- 22 managerial, and information systems;
- 23 (19) policyholder or enrollee services;
- 24 (20) auditing;
- 25 (21) reporting;
- 26 (22) database security;
- 27 (23) the administration of consumer disputes and
- 28 inquiries;
- 29 (24) external accreditation standards;
- 30 (25) the replacement of a group benefit plan or
- 31 workers' compensation policy or program;
- 32 (26) activities in connection with a sale, merger,
- 33 transfer, or exchange of all or part of a business or operating
- 34 unit;

1 (27) any activity that permits disclosure without
2 authorization under the federal Health Insurance Portability and
3 Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.), as
4 amended;

5 (28) disclosure that is required, or that is a lawful
6 or appropriate method to enforce the covered entity's rights or the
7 rights of other persons engaged, in carrying out a transaction or
8 providing a product or service that the consumer requests or
9 authorizes;

10 (29) claims administration, adjustment, and
11 management;

12 (30) any activity that is:

13 (A) otherwise permitted by law;

14 (B) required by a governmental reporting
15 authority; or

16 (C) required to comply with legal process; and

17 (31) any other insurance or health maintenance
18 organization functions the commissioner approves that are:

19 (A) necessary for appropriate performance of
20 insurance or health maintenance organization functions; and

21 (B) fair and reasonable to the interests of
22 consumers. (V.T.I.C. Art. 28B.04.)

23 Source Law

24 Art. 28B.04. A licensee may disclose nonpublic
25 personal health information to the extent that the
26 disclosure is necessary to perform the following
27 insurance functions on behalf of that licensee:

28 (1) the investigation or reporting of
29 actual or potential fraud, misrepresentation, or
30 criminal activity;

31 (2) underwriting;

32 (3) the placement or issuance of an
33 insurance policy;

34 (4) loss control services;

35 (5) ratemaking and guaranty fund
36 functions;

37 (6) reinsurance and excess loss insurance;

38 (7) risk management;

39 (8) case management;

40 (9) disease management;

41 (10) quality assurance;

42 (11) quality improvement;

43 (12) performance evaluation;

44 (13) health care provider credentialing

1 verification;
2 (14) utilization review;
3 (15) peer review activities;
4 (16) actuarial, scientific, medical, or
5 public policy research;
6 (17) grievance procedures;
7 (18) the internal administration of
8 compliance, managerial, and information systems;
9 (19) policyholder services;
10 (20) auditing;
11 (21) reporting;
12 (22) database security;
13 (23) the administration of consumer
14 disputes and inquiries;
15 (24) external accreditation standards;
16 (25) the replacement of a group benefit
17 plan or workers' compensation policy or program;
18 (26) activities in connection with a sale,
19 merger, transfer, or exchange of all or part of a
20 business or operating unit;
21 (27) any activity that permits disclosure
22 without authorization under the federal Health
23 Insurance Portability and Accountability Act of 1996
24 (42 U.S.C. Section 1320d et seq.), as amended;
25 (28) disclosure that is required, or is a
26 lawful or appropriate method to enforce the licensee's
27 rights or the rights of other persons engaged, in
28 carrying out a transaction or providing a product or
29 service that the consumer requests or authorizes;
30 (29) claims administration, adjustment,
31 and management;
32 (30) any activity otherwise permitted by
33 law, required pursuant to a governmental reporting
34 authority, or required to comply with legal process;
35 and
36 (31) any other insurance functions that
37 the commissioner approves that are:
38 (A) necessary for appropriate
39 performance of insurance functions; and
40 (B) fair and reasonable to the
41 interests of consumers.

42 Revisor's Note

43 V.T.I.C. Article 28B.04 refers to certain
44 "insurance functions" of a "licensee." The revised
45 law substitutes "insurance or health maintenance
46 organization functions" for "insurance functions"
47 because "licensee," as defined by V.T.I.C. Article
48 28B.01 and revised as "covered entity" in Section
49 602.001, includes a health maintenance organization,
50 which is not a traditional insurer. Similarly, the
51 revised law adds other terminology throughout this
52 section to reflect its application to both traditional
53 insurers and health maintenance organizations. For
54 example, see "evidence of coverage" in Section

1 602.053(3) and "enrollee" in Section 602.053(19).

2 [Sections 602.054-602.100 reserved for expansion]

3 SUBCHAPTER C. PENALTIES AND ENFORCEMENT

4 Revised Law

5 Sec. 602.101. PROHIBITION. A covered entity may not
6 knowingly or wilfully violate this chapter. (V.T.I.C. Art.
7 28B.07.)

8 Source Law

9 Art. 28B.07. A licensee may not knowingly or
10 wilfully violate this chapter.

11 Revised Law

12 Sec. 602.102. INJUNCTION. The attorney general may bring
13 an action for injunctive relief to restrain a violation of this
14 chapter. (V.T.I.C. Art. 28B.09, Sec. (a).)

15 Source Law

16 Art. 28B.09. (a) The attorney general may
17 institute an action for injunctive relief to restrain
18 a violation of this chapter.

19 Revised Law

20 Sec. 602.103. CIVIL PENALTY. (a) The attorney general may
21 bring an action for a civil penalty against a covered entity or
22 health care entity for a violation of this chapter.

23 (b) A civil penalty assessed under this section may not be
24 less than \$3,000 for each violation.

25 (c) If the court in which an action under this section is
26 pending finds that the violations have occurred with a frequency as
27 to constitute a pattern or practice, the court may assess a civil
28 penalty not to exceed \$250,000.

29 (d) A civil penalty authorized by this section is in
30 addition to any other civil, administrative, or criminal action
31 provided by law, including an action for injunctive relief provided
32 by Section 602.102. (V.T.I.C. Art. 28B.09, Secs. (b), (c), (d).)

33 Source Law

34 (b) In addition to the injunctive relief
35 provided by Subsection (a), the attorney general may
36 institute an action for civil penalties against a
37 covered entity or health care entity for a violation of

1 this chapter. A civil penalty assessed under this
2 section may not be less than \$3,000 for each violation.

3 (c) If the court in which an action under
4 Subsection (b) is pending finds that the violations
5 have occurred with a frequency as to constitute a
6 pattern or practice, the court may assess a civil
7 penalty not to exceed \$250,000.

8 (d) The civil penalty authorized by this article
9 is in addition to any other civil, administrative, or
10 criminal action provided by law.

11 Revised Law

12 Sec. 602.104. DISCIPLINARY ACTION. (a) In addition to a
13 penalty prescribed by this subchapter, a covered entity that
14 violates this chapter is subject to investigation, disciplinary
15 proceedings, and probation or suspension of the covered entity's
16 license or other form of authorization to engage in business.

17 (b) If there is evidence that a covered entity has engaged
18 in a pattern or practice of violating this chapter, the covered
19 entity's license or other form of authorization to engage in
20 business may be revoked. (V.T.I.C. Art. 28B.10.)

21 Source Law

22 Art. 28B.10. In addition to the penalties
23 prescribed by this chapter, a violation of this
24 chapter by a licensee is subject to investigation and
25 disciplinary proceedings, including probation or
26 suspension. Evidence of a pattern or practice of
27 violations under this chapter may subject the licensee
28 to license revocation.

29 Revised Law

30 Sec. 602.105. EXCLUSION FROM STATE PROGRAMS. If there is
31 evidence that a covered entity has engaged in a pattern or practice
32 of violating this chapter, in addition to the other penalties
33 prescribed by this subchapter, the covered entity shall be excluded
34 from participating in any state-funded health care program.
35 (V.T.I.C. Art. 28B.11.)

36 Source Law

37 Art. 28B.11. In addition to the penalties
38 prescribed by this chapter, a licensee shall be
39 excluded from participating in any state-funded health
40 care program if there is evidence that the licensee
41 engaged in a pattern or practice of violating this
42 chapter.

43 Revised Law

44 Sec. 602.106. REMEDIES AVAILABLE. This subchapter does

1 not affect any right of a person under other law to bring a cause of
2 action or otherwise seek relief with respect to conduct that
3 violates this chapter. (V.T.I.C. Art. 28B.12.)

4 Source Law

5 Art. 28B.12. This chapter does not affect any
6 right of a person under other law to bring a cause of
7 action or otherwise seek relief with respect to
8 conduct that is a violation of this chapter.

9 [Chapters 603-650 reserved for expansion]

10 SUBTITLE E. PREMIUM FINANCING

11 CHAPTER 651. FINANCING OF INSURANCE PREMIUMS

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1 CHAPTER 651. FINANCING OF INSURANCE PREMIUMS

2 SUBCHAPTER A. GENERAL PROVISIONS

3 Revised Law

4 Sec. 651.001. DEFINITIONS. In this chapter:

5 (1) "Annual percentage rate" means the annual
6 percentage rate of finance charge determined under the Consumer
7 Credit Protection Act and Regulation Z.

8 (2) "Consumer Credit Protection Act" means the
9 Consumer Credit Protection Act of 1970 (15 U.S.C. Section 1601 et
10 seq.; 18 U.S.C. Section 891 et seq.).

11 (3) "Insurance premium finance company" means:

12 (A) a person engaged in the business of making
13 loans under this chapter by entering into premium finance
14 agreements with insureds or prospective insureds;

15 (B) a person engaged in the business of acquiring
16 premium finance agreements from insurance agents or brokers or from
17 other insurance premium finance companies; or

18 (C) an insurance agent or broker making loans
19 under this chapter who holds premium finance agreements made and
20 delivered by insureds that are payable to the agent or broker or to
21 the agent's or broker's order.

22 (4) "Insured" means a person who enters into a premium
23 finance agreement with an insurance premium finance company.

24 (5) "Insurer" means an entity organized or authorized
25 to engage in the business of insurance under this code as a capital
26 stock insurance company, title insurance company, reciprocal or
27 interinsurance exchange, Lloyd's plan, fraternal benefit society,
28 mutual or mutual assessment company of any kind, statewide mutual
29 assessment company, local mutual aid association, burial
30 association, county or farm mutual insurance company, fidelity,
31 guaranty, or surety company, or trust company.

32 (6) "License holder" means an insurance premium
33 finance company that holds a license issued under Subchapter B.

34 (7) "Person" means an individual, partnership,

1 corporation, joint venture, trust, association, or other legal
2 entity, regardless of organization.

3 (8) "Premium finance agreement" means an agreement by
4 which an insured or prospective insured promises to pay to an
5 insurance premium finance company the amount advanced or to be
6 advanced under the agreement to an insurer or to an insurance agent
7 in payment of the premiums on an insurance contract.

8 (9) "Regulation Z" means the federal regulations
9 adopted under the Consumer Credit Protection Act as 12 C.F.R.
10 Section 226.1 et seq. (V.T.I.C. Art. 24.01, Subdivs. (1) (part),
11 (2), (4), (5), (6), (7), (8); New.)

12 Source Law

13 Art. 24.01. In this chapter:

14 (1) "Insurance premium finance company"
15 means:

16 (A) a person engaged in the business
17 of making loans under this chapter by entering into
18 premium finance agreements with insureds or
19 prospective insureds, . . . ;

20 (B) a person engaged in the business
21 of acquiring premium finance agreements from insurance
22 agents or brokers or other premium finance companies;
23 or

24 (C) an insurance agent or broker
25 making loans under this chapter who holds premium
26 finance agreements made and delivered by insureds
27 payable to him or her or his or her order.

28 (2) "Premium finance agreement" means an
29 agreement by which an insured or prospective insured
30 promises to pay to a premium finance company the amount
31 advanced or to be advanced under the agreement to an
32 insurer or to an insurance agent in payment of premium
33 on an insurance contract.

34 (4) "Licensee" means an insurance premium
35 finance company holding a license issued by the board
36 under this chapter.

37 (5) "Annual percentage rate" means the
38 annual percentage rate of finance charge as determined
39 in accordance with the Consumer Credit Protection Act
40 of 1970 (15 U.S.C.A. Section 1601 et seq.; 18 U.S.C.A.
41 Section 891 et seq.) and Regulation Z (12 C.F.R. 226.1
42 et seq.) promulgated under that Act.

43 (6) "Insured" means a person who enters
44 into a premium finance agreement with an insurance
45 premium finance company.

46 (7) "Person" means an individual,
47 partnership, corporation, joint venture, trust,
48 association, or any other legal entity, however
49 organized.

50 (8) "Insurer" as used in this chapter is
51 any capital stock company, title insurance company,
52 reciprocal or interinsurance exchange, Lloyd's
53 association, fraternal benefit society, mutual and
54 mutual assessment company of any kind or type,

1 statewide assessment association, local mutual aid,
2 burial association, county and farm mutual
3 association, fidelity, guaranty, and surety company,
4 or trust company. Said insurer shall be organized or
5 authorized to do business under the provisions of this
6 code.

7 Revisor's Note

8 (1) Subdivision (3), V.T.I.C. Article 24.01,
9 defines "board" to mean the State Board of Insurance.
10 The revised law omits the definition as unnecessary.
11 Chapter 685, Acts of the 73rd Legislature, Regular
12 Session, 1993, abolished the board and transferred its
13 functions to the commissioner of insurance and the
14 Texas Department of Insurance, as appropriate.
15 Section 31.001 of this code defines "commissioner" and
16 "department" for purposes of this code and the other
17 insurance laws of this state to mean the commissioner
18 of insurance and the Texas Department of Insurance.
19 Throughout this chapter, references to the board have
20 been changed to "commissioner" or "department"
21 appropriately. The omitted law reads:

22 (3) "Board" means the State
23 Board of Insurance.

24 (2) The revised law adds the definitions of
25 "Consumer Credit Protection Act" and "Regulation Z" to
26 avoid unnecessary and frequent repetition of the
27 substance of the definitions. The definitions are
28 derived from Subdivision (5), V.T.I.C. Article 24.01.

29 (3) Subdivision (8), V.T.I.C. Article 24.01,
30 refers to "statewide assessment association" and
31 "local mutual aid." The revised law substitutes
32 "statewide mutual assessment company" and "local
33 mutual aid association" for those terms, respectively,
34 for consistency of terminology in this code.

35 Revised Law

36 Sec. 651.002. CERTAIN CONDUCT NOT ENGAGING IN BUSINESS AS
37 INSURANCE PREMIUM FINANCE COMPANY. (a) The preparation or

1 delivery by an insurance agent of a premium finance agreement or
2 disclosure statement required by Section 651.155 on behalf of the
3 insured does not constitute engaging in business as an insurance
4 premium finance company.

5 (b) Subsection (a) does not apply to a premium finance
6 agreement held for the benefit of the insurance agent as provided by
7 Section 651.001(3)(C). (V.T.I.C. Art. 24.01, Subdiv. (1)(A)
8 (part); Art. 24.04, Sec. (c) (part).)

9 Source Law

10 Art. 24.01. [In this chapter:

11 (1) "Insurance premium finance company"
12 means:

13 (A)] . . . except that the
14 preparation and delivery of a premium finance
15 agreement or disclosure statement required by Section
16 (f), Article 24.11 of this chapter by an insurance
17 agent on behalf of the insured is not doing business as
18 an insurance premium finance company;

19 . . .

20 [Art. 24.04]

21 (c) . . . The preparation and delivery of a
22 premium finance agreement by an insurance agent on
23 behalf of the insured does not constitute doing
24 business as an insurance premium finance company,
25 unless the agreement is held for the benefit of the
26 agent in accordance with Article 24.01(1)(C) of this
27 chapter.

28 Revised Law

29 Sec. 651.003. RULES. (a) The commissioner may adopt and
30 enforce rules necessary to administer this chapter.

31 (b) The rules may contain classifications,
32 differentiations, or other provisions and provide for adjustments
33 or exceptions for any class of transactions necessary to:

34 (1) accomplish the purposes of this chapter;

35 (2) prevent circumvention or evasion of this chapter;

36 or

37 (3) facilitate compliance with this chapter.

38 (c) A rule adopted by the commissioner may not contain any
39 classification, differentiation, or other provision with respect
40 to any class of transactions or provide for any adjustment or
41 exception for any class of transactions that would result in a less
42 stringent disclosure requirement than required for that class of

1 transactions by the Consumer Credit Protection Act or Regulation Z.
2 (V.T.I.C. Art. 24.09.)

3 Source Law

4 Art. 24.09. The board may adopt and enforce
5 rules necessary to carry out this chapter. Those rules
6 may contain the classifications, differentiations, or
7 other provisions and may provide for the adjustments
8 and exceptions for any class of transactions that are
9 necessary to carry out the purposes of this chapter, to
10 prevent circumvention or evasion of this chapter, or
11 to facilitate compliance with this chapter. Those
12 rules may not contain any classification,
13 differentiation, or other provision with respect to or
14 provide for any adjustment or exception for any class
15 of transaction that would result in less stringent
16 disclosure requirements than afforded that class of
17 transaction under the Federal Consumer Credit
18 Protection Act of 1970 (15 U.S.C.A. Section 1601 et
19 seq.; 18 U.S.C.A. Section 891 et seq.) and the
20 applicable portions of Regulation Z (12 C.F.R. 226.1
21 et seq.).

22 Revised Law

23 Sec. 651.004. EMPLOYMENT OF EXAMINERS AND INVESTIGATORS;
24 PAYMENT OF EXPENSES. The department may:

25 (1) employ persons as necessary to examine or
26 investigate and make reports on alleged violations of this chapter
27 and compliance with any other provision of this code by a license
28 holder;

29 (2) pay the salaries and expenses of persons described
30 by Subdivision (1) and of all office employees; and

31 (3) pay an expense necessary to enforce this chapter.

32 (V.T.I.C. Art. 24.06, Sec. (d) (part).)

33 Source Law

34 (d) . . . The board may employ persons as
35 necessary to examine or investigate and make reports
36 on alleged violations of this chapter or on compliance
37 with the other provisions of this code by persons
38 licensed under this chapter and may pay the salaries
39 and expenses of those persons and of all office
40 employees and the expenses necessary to enforce this
41 chapter.

42 Revised Law

43 Sec. 651.005. DEPOSIT AND USE OF FEES. Each fee collected
44 under this chapter:

45 (1) shall be deposited to the credit of the Texas
46 Department of Insurance operating account; and

1 (2) may be used by the department to enforce this
2 chapter. (V.T.I.C. Art. 24.03, Sec. (h) (part); Art. 24.06, Sec.
3 (d) (part).)

4 Source Law

5 [Art. 24.03]

6 (h) Fees collected under this article shall be
7 deposited in the State Treasury to the credit of the
8 State Board of Insurance operating fund. . . .

9 [Art. 24.06]

10 (d) Fees collected under this chapter shall be
11 deposited in the State Treasury to the credit of the
12 State Board of Insurance operating fund. The board may
13 use any portion of those fees to enforce this
14 chapter. . . .

15 Revisor's Note

16 Section (h), V.T.I.C. Article 24.03, and Section
17 (d), V.T.I.C. Article 24.06, require fees to be
18 deposited in the state treasury to the credit of the
19 State Board of Insurance operating fund. Under
20 Chapter 4, Acts of the 72nd Legislature, 1st Called
21 Session, 1991, the Texas Department of Insurance
22 operating fund (the later name of the State Board of
23 Insurance operating fund) was converted to an account
24 in the general revenue fund. The revised law is
25 drafted accordingly.

26 Revised Law

27 Sec. 651.006. ASSESSMENTS. (a) A license holder shall pay
28 to the department:

29 (1) an amount imposed by the department to cover the
30 direct and indirect cost of examinations and investigations made
31 under this chapter; and

32 (2) a proportionate share of the general
33 administrative expense attributable to the regulation of license
34 holders.

35 (b) Each amount required by this section is in addition to
36 any investigation or license fee imposed under Subchapter B.
37 (V.T.I.C. Art. 24.06, Sec. (c).)

1 Source Law

2 (c) In addition to the investigation and license
3 fees set forth in Article 24.03 of this chapter, each
4 licensee shall pay to the board an amount assessed by
5 the board to cover the direct and indirect cost of
6 examinations and investigations made under this
7 article and a proportionate share of general
8 administrative expense attributable to the regulation
9 of the persons licensed under this chapter.

10 Revised Law

11 Sec. 651.007. APPLICABILITY OF CONSUMER CREDIT PROTECTION
12 ACT AND REGULATION Z. A transaction that is subject to this
13 chapter is also subject to:

14 (1) the Consumer Credit Protection Act; and

15 (2) the applicable provisions of Regulation Z.
16 (V.T.I.C. Art. 24.12.)

17 Source Law

18 Art. 24.12. A transaction, although subject to
19 this chapter, is also subject to the Consumer Credit
20 Protection Act of 1970 (15 U.S.C.A. Section 1601 et
21 seq.; 18 U.S.C.A. Section 891 et seq.) and those
22 applicable portions of Regulation Z (12 C.F.R. 226.1
23 et seq.) adopted under that Act.

24 Revised Law

25 Sec. 651.008. AUTHORITY OF GENERAL PROPERTY AND CASUALTY
26 AGENTS TO CHARGE INTEREST TO CERTAIN PERSONS. (a) Notwithstanding
27 any other law, a general property and casualty agent who holds a
28 license under Chapter 4051 may enter into a written agreement with a
29 purchaser of insurance from the agent that provides for the payment
30 of interest to the agent on any amount due to the agent for the
31 insurance purchased. The interest is computed at a rate not to
32 exceed the greater of:

33 (1) a rate allowed by Chapter 303, Finance Code; or

34 (2) the rate of one percent a month.

35 (b) A claim or defense of usury may not be raised in
36 connection with a written agreement under this section. (V.T.I.C.
37 Art. 24.20.)

38 Source Law

39 Art. 24.20. Notwithstanding any other provision
40 of law, any person, partnership, or corporation duly
41 licensed as a local recording agent under Article
42 21.14, Insurance Code, as amended, may enter into or

1 establish a written agreement with any purchaser of
2 insurance from the agent providing for the payment of
3 interest to the agent in an amount not to exceed the
4 greater of a rate allowed by Chapter 303, Finance Code,
5 or the rate of one percent a month, on any amount due
6 and owing to the agent for insurance purchased by the
7 purchaser. In those instances the claim or defense of
8 usury is prohibited.

9 Revisor's Note

10 (1) V.T.I.C. Article 24.20 refers to "Article
11 21.14, Insurance Code, as amended," revised as Chapter
12 4051 of this code. The revised law omits "as amended"
13 because under Section 311.027, Government Code (Code
14 Construction Act), unless expressly provided
15 otherwise, a reference to a statute includes all
16 reenactments, revisions, or amendments of the statute.
17 That provision applies to the revised law.

18 (2) V.T.I.C. Article 24.20 states that a "local
19 recording agent" may "enter into or establish" a
20 certain type of written agreement with a purchaser of
21 insurance. The revised law substitutes "general
22 property and casualty agent" for "local recording
23 agent" because the term "local recording agent" was
24 eliminated by Chapter 703, Acts of the 77th
25 Legislature, Regular Session, 2001, and a person who
26 performs the duties formerly performed by a local
27 recording agent in the context of residential property
28 insurance is now regulated as a "general property and
29 casualty agent" under Chapter 4051 of this code. In
30 addition, the revised law omits the reference to
31 "establish" as redundant. An agent who "enters into"
32 an agreement necessarily "establishes" an agreement.

33 (3) V.T.I.C. Article 24.20 refers to an amount
34 "due and owing" to an agent. The reference to "owing"
35 is omitted from the revised law because it is included
36 within the meaning of "due."

1 to insure the continuous regulation of
2 insurance premium finance companies by the
3 State Board of Insurance. This transfer
4 shall be made no later than January 1, 1980.

5 (b) The consumer credit commissioner
6 and the State Board of Insurance shall
7 cooperate to ensure an orderly transition
8 period. It is the intent and desire of the
9 legislature that the consumer credit
10 commissioner and the State Board of
11 Insurance consult with the state auditor,
12 the comptroller of public accounts, the
13 Legislative Budget Board, and any other
14 state agency for the orderly transfer of all
15 funds and records as outlined in Subsection
16 (a) of this section from the consumer
17 credit commissioner to the State Board of
18 Insurance.

19 [Sections 651.009-651.050 reserved for expansion]

20 SUBCHAPTER B. AUTHORITY TO ENGAGE IN BUSINESS

21 Revised Law

22 Sec. 651.051. LICENSE REQUIRED. Unless the person is a
23 license holder, a person may not:

24 (1) negotiate, transact, or engage in the business of
25 insurance premium financing in this state; or

26 (2) contract for, charge, or receive directly or
27 indirectly on or in connection with an insurance premium financing
28 any charge, regardless of whether the charge is for interest,
29 compensation, consideration, expense, or otherwise, if in the
30 aggregate the amount of the charge exceeds the amount the person
31 would be permitted by law to charge if the person were not a license
32 holder. (V.T.I.C. Art. 24.02, Sec. (a) (part).)

33 Source Law

34 Art. 24.02. (a) A person, without first
35 obtaining a license from the board as provided in
36 Section (d), Article 24.03 of this chapter, may not
37 negotiate, transact, or engage in the business of
38 insurance premium financing in this state or contract
39 for, charge, or receive directly or indirectly on or in
40 connection with any insurance premium financing any
41 charges, whether for interest, compensation,
42 consideration, expense, or otherwise, that in the
43 aggregate are greater than the person would be
44 permitted by law to charge if the person were not a
45 licensee under this chapter. . . .

46 Revised Law

47 Sec. 651.052. LICENSE FEE. (a) The department shall
48 establish the fee for a license under this subchapter in an amount

1 not to exceed \$200.

2 (b) The fee for a license issued after June 30 may not exceed
3 \$100.

4 (c) Section 201.001 applies to fees collected under this
5 section. (V.T.I.C. Art. 24.03, Secs. (f) (part), (h) (part).)

6 Source Law

7 (f) The fee for each license may be in an amount
8 not to exceed \$200 as determined by the board
9 and If a license is granted after June 30 of
10 any year, the fee may be in an amount not to exceed \$100
11 as determined by the board for that year.

12 (h) . . . Article 1.31A of this code applies to
13 fees collected under this article.

14 Revised Law

15 Sec. 651.053. ENTITLEMENT OF BANKS AND SAVINGS AND LOAN
16 ASSOCIATIONS TO LICENSE. (a) A bank or a savings and loan
17 association is entitled to receive a license under this subchapter
18 if the bank or savings and loan association:

19 (1) is engaging in business under the laws of this
20 state or the United States; and

21 (2) notifies the department of its intention to
22 operate under this chapter.

23 (b) On receipt of notice under Subsection (a)(2), the
24 department shall immediately issue a license to the bank or savings
25 and loan association. (V.T.I.C. Art. 24.02, Sec. (b).)

26 Source Law

27 (b) Any bank or savings and loan association
28 doing business under the laws of this state or the
29 United States is entitled to receive a license on
30 notification to the board of its intention to operate
31 under this chapter. The board shall immediately issue
32 a license to that bank or savings and loan association.

33 Revised Law

34 Sec. 651.054. APPLICATION FOR LICENSE; INVESTIGATION FEE;
35 EXEMPTION. (a) An application for a license to engage in the
36 business of insurance premium financing must:

37 (1) be in writing on a form prescribed by the
38 commissioner; and

39 (2) be accompanied by a nonrefundable investigation

1 fee in an amount not to exceed \$400 as established by the
2 department.

3 (b) A person who on January 1, 1980, held a license under
4 Chapter 3, Title 79, Revised Statutes (Article 5069-3.01 et seq.,
5 Vernon's Texas Civil Statutes), is not required to pay an
6 investigation fee.

7 (c) Section 201.001 applies to fees collected under this
8 section. (V.T.I.C. Art. 24.03, Secs. (a), (e), (g), (h) (part).)

9 Source Law

10 Art. 24.03. (a) Each application for a license
11 to engage in the business of insurance premium
12 financing must be in writing and in the form prescribed
13 by the board. It must be accompanied by an
14 investigation fee in an amount not to exceed \$400 as
15 determined by the board.

16 (e) The refusal of the board to issue a license
17 does not entitle the applicant to a return of any part
18 of the investigation fee that accompanied the
19 application.

20 (g) Any person holding a license under Chapter
21 342, Finance Code, on the effective date of this
22 chapter is required only to pay the license fee
23 required under this article and is not required to pay
24 the investigation fee required by Section (a) of this
25 article.

26 (h) . . . Article 1.31A of this code applies to
27 fees collected under this article.

28 Revisor's Note

29 (1) Section (e), V.T.I.C. Article 24.03,
30 provides that "[t]he refusal of the board to issue a
31 license does not entitle the applicant to a return of
32 any part of the investigation fee that accompanied the
33 application." The revised law substitutes a reference
34 to a "nonrefundable investigation fee" for the quoted
35 language as more concise and consistent with the
36 terminology used in other provisions of this code.

37 (2) Section (g), V.T.I.C. Article 24.03, refers
38 to a person "holding a license under Chapter 342,
39 Finance Code, on the effective date of this chapter"
40 (V.T.I.C. Chapter 24). V.T.I.C. Chapter 24 was
41 enacted as Chapter 825, Acts of the 66th Legislature,

1 Regular Session, 1979, effective January 1, 1980. At
2 the time of enactment, Section (g) referred to a person
3 holding a license under Chapter 3, Title 79, Revised
4 Civil Statutes of Texas. Chapter 3, Title 79, was
5 subsequently codified as Chapter 342, Finance Code,
6 and the reference in Section (g) was updated to reflect
7 that codification. However, in the context of
8 providing an exemption for a person licensed under
9 that chapter on January 1, 1980, it is more appropriate
10 to refer to the law as it existed on that date.
11 Accordingly, the revised law substitutes a reference
12 to a person "who on January 1, 1980, held a license
13 under Chapter 3, Title 79, Revised Statutes (Article
14 5069-3.01 et seq., Vernon's Texas Civil Statutes)."

15 Revised Law

16 Sec. 651.055. REFUSAL TO ISSUE LICENSE. The department may
17 refuse to issue a license to an applicant if the department
18 determines that:

19 (1) the financial responsibility, experience,
20 character, or general fitness of the applicant or any person
21 associated with the applicant does not command the confidence of
22 the community and does not warrant the belief that the applicant
23 will engage in the business of insurance premium financing
24 honestly, fairly, and efficiently; or

25 (2) the applicant does not have available for the
26 operation of the business net assets of at least \$25,000. (V.T.I.C.
27 Art. 24.03, Sec. (c).)

28 Source Law

29 (c) The board may refuse to issue a license if it
30 finds that:

31 (1) the financial responsibility,
32 experience, character, or general fitness of the
33 applicant or any person associated with the applicant
34 does not command the confidence of the community and
35 does not warrant the belief that the business will be
36 conducted honestly, fairly, and efficiently; or

37 (2) the applicant does not have available
38 for the operation for the business net assets of at
39 least \$25,000.

1 Revised Law

2 Sec. 651.056. NOTICE OF ACTION ON APPLICATION. Not later
3 than the 90th day after the date the department receives an
4 application under Section 651.054, the department shall notify the
5 applicant that:

6 (1) the application has been approved and the
7 department will issue a license to the applicant on payment of the
8 required license fee; or

9 (2) the application has been denied. (V.T.I.C. Art.
10 24.03, Sec. (b).)

11 Source Law

12 (b) Within 90 days after receipt of an
13 application, the board shall notify the applicant
14 that:

15 (1) the application has been approved and
16 a license will be issued on payment of the appropriate
17 license fee; or

18 (2) the application has been denied.

19 Revised Law

20 Sec. 651.057. ISSUANCE OF LICENSE. After approval of an
21 application and on receipt of the required license fee, the
22 department shall:

23 (1) issue a license authorizing the license holder to
24 engage in business as an insurance premium finance company at the
25 location specified in the license holder's application; and

26 (2) send the license to the applicant. (V.T.I.C. Art.
27 24.03, Secs. (d), (f) (part).)

28 Source Law

29 (d) After approval and on receipt of the license
30 fee, the board shall execute the license to engage in
31 the business of a premium finance company at the
32 location specified in the application and shall
33 transmit the license to the applicant.

34 (f) The fee for each license . . . shall be paid
35 to the board. . . .

36 Revisor's Note

37 Section (d), V.T.I.C. Article 24.03, provides
38 that, after approval of an application and on receipt
39 of the required license fee, the board "shall execute

1 the license to engage in the business of a premium
2 finance company." The revised law substitutes "issue"
3 for "execute" because, in this context, the terms are
4 synonymous and "issue" is more commonly used in the
5 licensing provisions of other statutes.

6 Revised Law

7 Sec. 651.058. RECIPROCAL LICENSE. The department may
8 waive any license requirement for an applicant who holds a valid
9 license from another state that has license requirements
10 substantially equivalent to the requirements prescribed by this
11 state. (V.T.I.C. Art. 24.03, Sec. (k).)

12 Source Law

13 (k) The board may waive any license requirement
14 for an applicant with a valid license from another
15 state having license requirements substantially
16 equivalent to those of this state.

17 Revised Law

18 Sec. 651.059. ISSUANCE OF MULTIPLE LICENSES. The
19 department may issue a person more than one license under this
20 subchapter but may not issue one person more than 60 of those
21 licenses. (V.T.I.C. Art. 24.02, Sec. (a) (part).)

22 Source Law

23 (a) . . . The board may issue more than one
24 license but not more than 60 licenses to any one person
25 on compliance with this chapter for each license.

26 Revised Law

27 Sec. 651.060. SINGLE BUSINESS LOCATION AUTHORIZED BY
28 LICENSE. A license authorizes the license holder to maintain only
29 one location where the business of insurance premium financing may
30 be conducted. (V.T.I.C. Art. 24.02, Sec. (a) (part).)

31 Source Law

32 (a) . . . A license issued under this chapter
33 allows the holder to maintain only one office from
34 which business may be conducted. . . .

35 Revised Law

36 Sec. 651.061. APPEARANCE OF LICENSE; POSTING. (a) A
37 license must state the name and address of the license holder.

1 (b) The license must be conspicuously posted at the location
2 where the license holder engages in the business of insurance
3 premium financing. (V.T.I.C. Art. 24.04, Sec. (a) (part).)

4 Source Law

5 Art. 24.04. (a) A license issued under this
6 chapter must state the name and address of the
7 licensee. The license shall be conspicuously posted
8 in the specified office of the licensee. . . .

9 Revised Law

10 Sec. 651.062. TRANSFER OR ASSIGNMENT OF LICENSE
11 PROHIBITED. A license may not be transferred or assigned.
12 (V.T.I.C. Art. 24.04, Sec. (a) (part).)

13 Source Law

14 (a) . . . Except as provided in this chapter,
15 the license is not transferable or assignable. . . .

16 Revisor's Note

17 Section (a), V.T.I.C. Article 24.04, provides
18 that "[e]xcept as provided in this chapter" (Chapter
19 24), a license issued under V.T.I.C. Chapter 24 is not
20 transferable or assignable. The revised law omits the
21 quoted language as unnecessary because Chapter 24 does
22 not otherwise authorize the transfer or assignment of
23 a license.

24 Revised Law

25 Sec. 651.063. TERM OF LICENSE. Unless a staggered renewal
26 system is adopted under Section 651.065, a license is issued for the
27 calendar year and remains valid until December 31 of that year,
28 unless suspended, revoked, or surrendered in accordance with
29 Section 651.204 or 651.206. (V.T.I.C. Art. 24.03, Sec. (f)
30 (part).)

31 Source Law

32 (f) . . . Except as may be provided by a
33 staggered renewal system adopted under Section (j) of
34 this article, each license shall be issued for the
35 calendar year and shall remain in force until December
36 31 of each year, unless suspended, revoked, or
37 surrendered in accordance with Article 24.05 of this
38 chapter. . . .

1 Revised Law

2 Sec. 651.064. PROCEDURE FOR LICENSE RENEWAL. (a) A
3 license holder may renew an unexpired license by paying the
4 required renewal fee to the department.

5 (b) A person whose license has been expired for 90 days or
6 less may renew the license by paying to the department:

7 (1) the required renewal fee; and

8 (2) an additional fee equal to one-half of the
9 original license fee.

10 (c) A person whose license has been expired for more than 90
11 days but less than two years may renew the license by paying to the
12 department:

13 (1) all unpaid renewal fees; and

14 (2) an additional fee equal to the original license
15 fee.

16 (d) A person whose license has been expired for two years or
17 more may not renew the license. The person may obtain a new license
18 by complying with the requirements and procedures for obtaining an
19 original license.

20 (e) Not later than the 30th day before the date a person's
21 license expires, the department shall send written notice of the
22 impending license expiration to the person at the person's last
23 known address.

24 (f) This section may not be construed to prevent the
25 department from denying or refusing to renew a license under an
26 applicable law or a rule adopted by the commissioner. (V.T.I.C.
27 Art. 24.03, Sec. (i).)

28 Source Law

29 (i) An unexpired license may be renewed by
30 paying the required renewal fee to the board before the
31 expiration date of the license. If a license has been
32 expired for not longer than 90 days, the license may be
33 renewed by paying to the board the required renewal fee
34 and a fee that is one-half of the original license fee.
35 If a license has been expired for longer than 90 days
36 but less than two years, the license may be renewed by
37 paying to the board all unpaid renewal fees and a fee
38 that is equal to the original license fee. If a
39 license has been expired for two years or longer, the

1 license may not be renewed. A new license may be
2 obtained by complying with the requirements and
3 procedures for obtaining an original license. At
4 least 30 days before the expiration of a license, the
5 commissioner of insurance shall send written notice of
6 the impending license expiration to the licensee at
7 his last known address. This section may not be
8 construed to prevent the board from denying or
9 refusing to renew a license under applicable law or
10 rules of the State Board of Insurance.

11 Revised Law

12 Sec. 651.065. STAGGERED RENEWAL SYSTEM. (a) The
13 commissioner by rule may adopt a system under which licenses expire
14 on various dates during the year.

15 (b) For a year in which the license expiration date is less
16 than one year from the date of license issuance or the anniversary
17 of that date, the license fee shall be prorated so that each license
18 holder pays only that portion of the license fee allocable to the
19 number of months during which the license is valid. On each
20 subsequent renewal of the license, a license holder must pay the
21 total renewal fee. (V.T.I.C. Art. 24.03, Sec. (j).)

22 Source Law

23 (j) The board by rule may adopt a system under
24 which licenses expire on various dates during the
25 year. For the year in which the license expiration
26 date is less than one year from the issuance or
27 anniversary date, the license fee shall be prorated on
28 a monthly basis so that each licensee shall pay only
29 that portion of the license fee that is allocable to
30 the number of months during which the license is valid.
31 On each subsequent renewal of the license, the total
32 license renewal fee is payable.

33 [Sections 651.066-651.100 reserved for expansion]

34 SUBCHAPTER C. REGULATION OF INSURANCE PREMIUM FINANCE
35 COMPANIES

36 Revised Law

37 Sec. 651.101. BOOKS, ACCOUNTS, AND RECORDS. (a) A license
38 holder shall maintain books, accounts, and records in sufficient
39 detail to enable a representative of the department to determine
40 whether the license holder is in compliance with this chapter and
41 rules adopted by the commissioner.

42 (b) A license holder shall maintain for inspection the
43 license holder's books, accounts, and records, including any cards

1 used in a card system, for at least four years after the date the
2 final entry of any premium finance agreement is recorded in those
3 books, accounts, and records. (V.T.I.C. Art. 24.10, Sec. (a).)

4 Source Law

5 Art. 24.10. (a) The licensee shall keep and use
6 books, accounts, and records in enough detail to
7 enable representatives of the board to determine
8 whether the licensee is complying with this chapter
9 and with the rules and regulations lawfully made by the
10 board. The licensee shall preserve and keep available
11 for inspection those books, accounts, and records,
12 including cards used in a card system, if any, for at
13 least four years after the final entry of any premium
14 finance agreement is recorded in those books,
15 accounts, and records.

16 Revisor's Note

17 (1) Section (a), V.T.I.C. Article 24.10,
18 requires a license holder to "keep and use" books,
19 accounts, and records, and to "preserve and keep
20 available" those books, accounts, and records. The
21 revised law substitutes "maintain" for "keep and use"
22 and for "preserve and keep available" because, in this
23 context, "maintain" is synonymous with both phrases
24 and is more concise and more commonly used.

25 (2) Section (a), V.T.I.C. Article 24.10, refers
26 to "rules and regulations lawfully made by the board."
27 The revised law omits the reference to "regulations"
28 because under Section 311.005(5), Government Code
29 (Code Construction Act), applicable to the revised
30 law, a rule is defined to include a regulation. The
31 revised law also omits the reference to "lawfully
32 made" as unnecessary because the commissioner of
33 insurance may adopt rules only in accordance with law,
34 and therefore "lawfully made" does not add to the clear
35 meaning of the law.

36 Revised Law

37 Sec. 651.102. ANNUAL REPORT. On or before April 1 of each
38 year, a license holder shall file with the department a report
39 containing information required by the department concerning the

1 business and operations of the license holder during the preceding
2 calendar year at each licensed location where the license holder
3 engages in the business of insurance premium financing in this
4 state. (V.T.I.C. Art. 24.10, Sec. (b).)

5 Source Law

6 (b) On or before the first day of April of each
7 year each licensee shall file with the board a report
8 giving the information that the board requires
9 concerning the business and operations during the
10 preceding calendar year of each licensed place of
11 business conducted by the licensee in the state.

12 Revised Law

13 Sec. 651.103. BUSINESS NAME. A license holder may not
14 engage in the business of insurance premium financing under any
15 name other than the name stated on the license. (V.T.I.C. Art.
16 24.04, Sec. (c) (part).)

17 Source Law

18 (c) A licensee may not conduct the business of
19 premium financing provided for by this chapter under
20 any name or . . . other than that stated in the
21 license. . . .

22 Revised Law

23 Sec. 651.104. BUSINESS LOCATION. A license holder may not
24 engage in the business of insurance premium financing at any
25 location other than the address stated on the license. (V.T.I.C.
26 Art. 24.04, Sec. (c) (part).)

27 Source Law

28 (c) A licensee may not conduct the business of
29 premium financing provided for by this chapter . . .
30 at any place of business other than that stated in the
31 license. . . .

32 Revised Law

33 Sec. 651.105. RELOCATION OF PLACE OF BUSINESS. (a) A
34 license holder who proposes to relocate the place where the holder
35 engages in the business of insurance premium financing shall give
36 written notice of the proposed change to the department.

37 (b) If the department approves the proposed relocation, the
38 department shall issue an endorsement to the license holder
39 indicating the change and the date of the change.

1 (c) The endorsement authorizes the license holder to engage
2 in the business of insurance premium financing at the new location.
3 The license holder shall attach the endorsement to the license for
4 that location. (V.T.I.C. Art. 24.04, Sec. (a) (part).)

5 Source Law

6 (a) . . . Before a licensee changes an office
7 from one location to another, the licensee shall give
8 written notice of the change to the board which, if it
9 approves the change, shall issue an endorsement
10 indicating the change and the date of the change. The
11 licensee shall attach the endorsement to the license
12 for that office. The endorsement constitutes
13 authority for the operation of the business under the
14 license at the new location.

15 Revised Law

16 Sec. 651.106. BUSINESS PREMISES. (a) Except as provided
17 by Subsection (b), a license holder may engage in the business of
18 insurance premium financing:

19 (1) in any office, suite, room, or place of business in
20 which any other business is solicited or engaged in; or

21 (2) in association or in conjunction with any other
22 business.

23 (b) Subsection (a) does not apply if the department:

24 (1) determines, after a hearing, that the conduct by
25 the license holder of the other business at the location for which
26 the license was issued has concealed evasions of this chapter; and

27 (2) orders the license holder in writing to stop
28 engaging in the business of insurance premium financing at that
29 location. (V.T.I.C. Art. 24.04, Sec. (b).)

30 Source Law

31 (b) A licensee may conduct the business of
32 premium financing under this chapter in any office,
33 suite, room, or place of business in which any other
34 business is solicited or engaged in or in association
35 or conjunction with any other business, unless the
36 board:

37 (1) finds, after a hearing, that the
38 conduct by the licensee of the other business in the
39 particular licensed office has concealed evasions of
40 this chapter; and

41 (2) orders the licensee in writing to stop
42 conducting the business of premium financing in that
43 office.

1 Revised Law

2 Sec. 651.107. ENGAGING IN BUSINESS BY MAIL OR OUTSIDE THE
3 COMMUNITY. This chapter does not prohibit a license holder from
4 engaging in the business of insurance premium financing:

5 (1) by mail; or

6 (2) with persons who do not reside in the same
7 community as the licensed location. (V.T.I.C. Art. 24.04, Sec.
8 (d).)

9 Source Law

10 (d) Nothing in this chapter limits the premium
11 financing of any licensee to residents of the
12 community in which the licensed office is situated or
13 prohibits the licensee from conducting premium
14 financing by mail.

15 Revised Law

16 Sec. 651.108. CERTAIN CHARGES PROHIBITED. In connection
17 with a premium finance agreement entered into under this chapter,
18 an insurance charge or any other charge or fee may not be imposed
19 unless the charge or fee is authorized by this chapter. (V.T.I.C.
20 Art. 24.15 (part).)

21 Source Law

22 Art. 24.15. . . . On insurance premium finance
23 agreements made under this chapter, no insurance
24 charges or any other charge or fee, except those
25 authorized by this chapter, are permitted.

26 Revised Law

27 Sec. 651.109. LIMITATIONS ON RATES AND CHARGES. (a) An
28 insurance premium finance company may not take or receive from an
29 insured a greater rate or charge than is authorized by Chapter 342,
30 Finance Code.

31 (b) For purposes of this section, a charge begins on the
32 earlier of:

33 (1) the date from which the insurer requires payment
34 of the premium and payment was made to the insurer for the financed
35 policy; or

36 (2) the effective date of the policy.

37 (c) The finance charge is computed on the balance of the

1 premiums due after subtracting any down payment made by the insured
2 in accordance with the premium finance agreement. (V.T.I.C. Art.
3 24.15 (part).)

4 Source Law

5 Art. 24.15. A premium finance company may not
6 take or receive from an insured a greater rate or
7 charge than is provided by Chapter 342, Finance Code.
8 Those charges begin on the date from which the
9 insurance company requires payment of the premium and
10 payment was made to the insurance company for the
11 financed policy or on the effective date of the policy,
12 whichever is earlier. The finance charge shall be
13 computed on the balance of the premiums due after
14 subtracting the down payment made by the insured in
15 accordance with the premium finance agreement. . . .

16 Revised Law

17 Sec. 651.110. REBATE OF FINANCE CHARGE. (a) An insurance
18 premium finance company or an employee of an insurance premium
19 finance company may not:

20 (1) pay, allow, or offer to pay or allow in any manner
21 to an insurance agent or broker or an employee of an insurance agent
22 or broker or to any other person any consideration or compensation,
23 from the charge for financing specified in the premium finance
24 agreement or from another source; or

25 (2) give or offer to give any valuable consideration
26 or inducement of any kind directly or indirectly to an insurance
27 agent or broker or an employee of an insurance agent or broker.

28 (b) Subsection (a)(2) does not prohibit the giving or
29 offering of an article of merchandise that has a value of \$1 or less
30 on which there is an advertisement of the insurance premium finance
31 company.

32 (c) Subsection (a) does not prohibit an insurance premium
33 finance company from making a payment under a contractual agreement
34 with a validly organized and operating association of insurance
35 agents or a subsidiary of the association if no part of a payment
36 received under the agreement:

37 (1) is distributed to an insurance agent or broker or
38 an employee of an insurance agent or broker; or

39 (2) inures directly to the benefit of a member of the

1 association or an employee of the member.

2 (d) A contractual agreement under Subsection (c):

3 (1) must be in writing; and

4 (2) is not valid until department approval is
5 received. (V.T.I.C. Art. 24.14, Sec. (a).)

6 Source Law

7 Art. 24.14. (a) A premium finance company or an
8 employee of such a company may not pay or allow or
9 offer to pay or allow in any manner whatsoever to an
10 insurance agent or broker or any employee of an
11 insurance agent or broker or to any other person any
12 consideration or compensation whatsoever, either from
13 the charge for financing specified in the premium
14 finance agreement or otherwise, or give or offer to
15 give any valuable consideration or inducement of any
16 kind directly or indirectly to an insurance agent or
17 broker or any employee of an insurance agent or broker
18 other than an article of merchandise not exceeding \$1
19 in value on which there is an advertisement of the
20 premium finance company, except that nothing in this
21 article prevents payments by a premium finance company
22 under contractual arrangements with a validly
23 organized and operating association of insurance
24 agents or its subsidiary, so long as no part of any
25 funds received under the agreement is distributed to
26 any insurance agent or broker or employee of any
27 insurance agent or broker or inures directly to the
28 benefit of any member of the association or employee of
29 the member. All of those contractual agreements must
30 be in writing and are not valid until approval of the
31 board has been received.

32 Revised Law

33 Sec. 651.111. DECEPTIVE ADVERTISING PROHIBITED. (a) A
34 license holder may not advertise or cause to be advertised in any
35 manner any false, misleading, or deceptive statement or
36 representation with regard to the rates, terms, or conditions of a
37 premium finance agreement.

38 (b) If rates or charges are stated in advertising, the
39 license holder must express the rates or charges in terms of a
40 simple annual percentage rate as defined by federal law. (V.T.I.C.
41 Art. 24.13.)

42 Source Law

43 Art. 24.13. A licensee may not advertise or
44 cause to be advertised in any manner whatsoever any
45 false, misleading, or deceptive statement or
46 representation with regard to the rates, terms, or
47 conditions of any premium finance agreement. If rates
48 or charges are stated in advertising, the licensee
49 shall express them in terms of a simple annual

1 percentage rate as defined by federal law.

2 [Sections 651.112-651.150 reserved for expansion]

3 SUBCHAPTER D. PREMIUM FINANCE AGREEMENTS

4 Revised Law

5 Sec. 651.151. REQUIRED FORM AND CONTENTS OF PREMIUM FINANCE
6 AGREEMENT. (a) A premium finance agreement must be in writing on a
7 form approved by the commissioner.

8 (b) A premium finance agreement must be dated and signed by
9 the insured. An agreement may be signed on behalf of the insured by
10 the insured's agent if:

11 (1) the agreement contains policies for other than
12 personal, family, or household purposes; and

13 (2) the premiums for the policies exceed \$1,000.

14 (c) A premium finance agreement must contain:

15 (1) the name and business address of the insurance
16 agent or broker negotiating the related insurance contract;

17 (2) the name and residence or business address of the
18 insured as specified by the insured;

19 (3) the name and business location of the insurance
20 premium finance company to which payments are to be made;

21 (4) a description of each insurance contract involved;

22 (5) the amount of the premium for each insurance
23 contract;

24 (6) the total amount of the premiums for all insurance
25 contracts;

26 (7) the amount of any down payment;

27 (8) the principal balance, which is the difference
28 between the amounts under Subdivisions (6) and (7);

29 (9) the total amount of the finance charge, which must
30 describe each amount included and use the term "finance charge";

31 and

32 (10) the balance payable by the insured, which is the
33 sum of the amounts under Subdivisions (8) and (9). (V.T.I.C. Art.
34 24.11, Secs. (a), (b), (c).)

1 Source Law

2 Art. 24.11. (a) A premium finance agreement
3 shall be in writing on a form approved by the board.

4 (b) The agreement shall be dated and signed by
5 the insured. If the agreement contains policies for
6 other than personal, family, or household purposes and
7 if the premiums for the policies exceed \$1,000, it may
8 be signed on behalf of the insured by the insured's
9 agent.

10 (c) The agreement must contain:

11 (1) the name and business address of the
12 insurance agent or insurance broker negotiating the
13 related insurance contract;

14 (2) the name and residence or business
15 address of the insured as specified by the insured;

16 (3) the name and place of business of the
17 premium finance company to which payments are to be
18 made;

19 (4) a description of each insurance
20 contract involved;

21 (5) the amount of the premium for each
22 insurance contract;

23 (6) the total amount of the premiums for
24 all insurance contracts;

25 (7) the amount of the down payment;

26 (8) the principal balance (difference
27 between items (6) and (7));

28 (9) the total amount of the finance
29 charge, with a description of each amount included,
30 using the term "finance charge"; and

31 (10) the balance payable by the insured
32 (sum of items (8) and (9)).

33 Revised Law

34 Sec. 651.152. OTHER REQUIRED CONTENTS. In addition to the
35 items required by Section 651.151, a premium finance agreement must
36 contain the following, as applicable:

37 (1) the finance charge expressed as an annual
38 percentage rate, using the term "annual percentage rate";

39 (2) the number of installments required under the
40 agreement;

41 (3) the amount of each installment expressed in
42 dollars;

43 (4) the due date or period of each installment;

44 (5) the amount or method of computing the amount of any
45 default or delinquency charge that is payable in the event of late
46 payment; and

47 (6) the method of computing any unearned portion of
48 the finance charge in the event of prepayment of the obligation.

49 (V.T.I.C. Art. 24.11, Sec. (d).)

1 Source Law

2 (d) The premium finance agreement in addition
3 must contain the following items as applicable:

4 (1) the finance charge expressed as an
5 annual percentage rate, using the term "annual
6 percentage rate";

7 (2) the number of installments required,
8 the amount of each installment expressed in dollars,
9 and the due date or period of each installment;

10 (3) the amount or method of computing the
11 amount of any default or delinquency charge that is
12 payable in the event of late payment; and

13 (4) identification of the method of
14 computing any unearned portion of the finance charge
15 in the event of prepayment of the obligation.

16 Revised Law

17 Sec. 651.153. FORM OF DISCLOSURES. (a) The disclosures
18 required by Sections 651.151 and 651.152 must be made clearly,
19 conspicuously, and in meaningful sequence.

20 (b) If the term "finance charge" or "annual percentage rate"
21 is required to be used, the term must be printed more conspicuously
22 than other required terminology.

23 (c) Each numerical amount or percentage must be expressed as
24 a figure and:

25 (1) legibly handwritten; or

26 (2) printed in not less than the equivalent of
27 10-point type, 75/1,000-inch computer type, or elite-size
28 typewritten numerals. (V.T.I.C. Art. 24.11, Sec. (e).)

29 Source Law

30 (e) The disclosures required to be given shall
31 be made clearly, conspicuously, and in meaningful
32 sequence. Where the terms "finance charge" and
33 "annual percentage rate" are required to be used, they
34 shall be printed more conspicuously than other
35 terminology required by this chapter. All numerical
36 amounts and percentages shall be stated in figures and
37 shall be printed in not less than the equivalent of
38 10-point type, 75/1,000 inch computer type, or elite
39 size typewritten numerals or shall be legibly
40 handwritten.

41 Revised Law

42 Sec. 651.154. CONSOLIDATION OF INCREASE ATTRIBUTABLE TO
43 AMENDMENT OF RATE CLASSIFICATION. (a) If, in a premium finance
44 agreement, a change in an insured's policy that is caused by an
45 amendment of the rate classification by endorsement or otherwise
46 results in an increased principal balance and the amount under the

1 previous contract has not been fully paid, the subsequent increase,
2 at the insured's option, may be consolidated with the previous
3 contract if the agreement provides for consolidation.

4 (b) A consolidation under this section may be accomplished
5 by a memorandum of agreement between the agent and the insured if,
6 before the first scheduled payment date of the amended transaction,
7 the insurance premium finance company provides to the insured the
8 following information in writing:

- 9 (1) the amount of the premium increase;
- 10 (2) the down payment on the increase;
- 11 (3) the principal amount of the increase;
- 12 (4) the total amount of any finance charge on the
13 increase;
- 14 (5) the total of the additional balance due;
- 15 (6) the outstanding balance due under the original
16 agreement;
- 17 (7) the balance due under the consolidated agreement;
- 18 (8) the annual percentage rate of any finance charge
19 on the additional balance due;
- 20 (9) the revised schedule of payments;
- 21 (10) the amount or method of computing the amount of
22 any default, deferment, or similar charge authorized by Chapter
23 342, Finance Code, that is payable in the event of late payment; and
24 (11) the method of computing any unearned portion of
25 the finance charge in the event of prepayment of the obligation.
26 (V.T.I.C. Art. 24.11, Secs. (g), (h).)

27 Source Law

28 (g) If, in a premium finance agreement, changes
29 in an insured's policy due to amending of the rate
30 classification by endorsement or otherwise result in
31 an increased principal balance and the amount under
32 the previous contract has not been fully paid, the
33 subsequent increase may at the insured's option be
34 included in and consolidated with the previous
35 contract, if so provided in the premium finance
36 agreement.

37 (h) Those additions may be accomplished by a
38 memorandum of agreement between the agent and the
39 insured, if before the first scheduled payment date of
40 the amended transaction the premium finance company

1 gives to the insured the following information in
2 writing:

- 3 (1) the amount of the premium increase;
- 4 (2) the down payment on increase;
- 5 (3) the principal amount of increase;
- 6 (4) the total amount of finance charge on
7 increase;
- 8 (5) the total of additional balance due;
- 9 (6) the outstanding balance of original
10 agreement;
- 11 (7) the consolidated agreement balance;
- 12 (8) the annual percentage rate of finance
13 charge on additional balance due;
- 14 (9) the revised schedule of payments;
- 15 (10) the amount or method of computing the
16 amount of any default, deferment, or similar charges
17 authorized in Chapter 342, Finance Code, payable in
18 the event of late payments; and
- 19 (11) identification of the method of
20 computing any unearned portion of the finance charge
21 in the event of prepayment of the obligation.

22 Revisor's Note

23 Section (g), V.T.I.C. Article 24.11, provides
24 that an increase in the principal balance due under a
25 premium finance agreement that is caused by certain
26 changes in the insured's policy may be "included in and
27 consolidated with" the previous policy. The revised
28 law omits "included in" because its meaning is
29 included within the meaning of "consolidated with."

30 Revised Law

31 Sec. 651.155. RESPONSIBILITIES OF INSURANCE AGENT. An
32 insurance agent shall:

- 33 (1) prepare a premium finance agreement; and
- 34 (2) deliver to the insured each disclosure statement
35 required by law. (V.T.I.C. Art. 24.11, Sec. (f) (part).)

36 Source Law

37 (f) . . . The insurance agent is responsible
38 for the completion of the insurance premium finance
39 agreement and for delivery to the insured any and all
40 disclosure statements that are required by any
41 existing law.

42 Revised Law

43 Sec. 651.156. TAKING OF INCOMPLETE PREMIUM FINANCE
44 AGREEMENT PROHIBITED. A license holder may not take a premium
45 finance agreement that has not been fully completed and executed at
46 the time the agreement is executed. (V.T.I.C. Art. 24.11, Sec. (f))

1 (part).)

2 Source Law

3 (f) It shall be a violation of this Act for any
4 licensee to take an insurance premium finance
5 agreement that has not been fully completed and
6 executed at the time the insurance premium finance
7 agreement is executed. . . .

8 Revised Law

9 Sec. 651.157. PERFECTION OF PREMIUM FINANCE AGREEMENT AS
10 SECURED TRANSACTION: FILING NOT REQUIRED. Filing of a premium
11 finance agreement or a financing statement is not necessary to
12 perfect the agreement as a secured transaction against a creditor,
13 subsequent purchaser, pledgee, encumbrancer, successor, or assign
14 of the insured or any other party. (V.T.I.C. Art. 24.14, Sec. (b).)

15 Source Law

16 (b) Filing of a premium finance agreement or a
17 financing statement is not necessary to perfect the
18 validity of such an agreement as a secured transaction
19 against creditors, subsequent purchasers, pledgees,
20 encumbrancers, successors, or assigns of the insured
21 or any other party.

22 Revised Law

23 Sec. 651.158. PREPAYMENT AND REFUND. (a) Notwithstanding
24 the provisions of any premium finance agreement to the contrary, an
25 insured may pay the balance due under the agreement in full at any
26 time before the maturity of the final installment of the balance.

27 (b) If an insured pays a premium finance agreement in full
28 as authorized by this section and the agreement included an amount
29 for a charge, the insured is entitled to receive for the prepayment
30 by cash or renewal a refund credit in accordance with Subchapter H,
31 Chapter 342, Finance Code, and rules adopted under that subchapter.
32 If the amount of the credit for prepayment is less than \$1, the
33 insured is not entitled to a refund credit. (V.T.I.C. Art. 24.16.)

34 Source Law

35 Art. 24.16. Notwithstanding the provisions of
36 any premium finance agreement to the contrary, any
37 insured may pay it in full at any time before the
38 maturity of the final installment of the balance of the
39 agreement, and if the insured does so and the agreement
40 included an amount for a charge, the insured shall
41 receive for the prepayment either by cash or by renewal
42 a refund credit in accordance with the provisions for

1 refunds contained in Subchapter H, Chapter 342,
2 Finance Code, and the regulations issued under that
3 article. Where the amount of the credit for
4 anticipation of payments is less than \$1, no refund
5 need be made.

6 Revisor's Note

7 V.T.I.C. Article 24.16 refers to "regulations"
8 issued under under Subchapter H, Chapter 342, Finance
9 Code. Throughout this chapter, the revised law
10 substitutes "rules" for "regulations" because, in this
11 context, the terms are synonymous and because under
12 Section 311.005(5), Government Code (Code
13 Construction Act), a rule is defined to include a
14 regulation. That definition applies to the revised
15 law.

16 Revised Law

17 Sec. 651.159. DEFAULT CHARGE. A premium finance agreement
18 may provide for the payment of a default charge by the insured as
19 provided by Section 342.203, Finance Code, this code, or a rule
20 adopted under those statutes. (V.T.I.C. Art. 24.17, Sec. (a).)

21 Source Law

22 Art. 24.17. (a) A premium finance agreement may
23 provide for the payment of a default charge by the
24 insured as provided in Section 342.203, Finance Code,
25 the Insurance Code, and the regulations issued under
26 those statutes.

27 Revised Law

28 Sec. 651.160. POWER OF ATTORNEY. A premium finance
29 agreement may contain a power of attorney that enables the
30 insurance premium finance company to cancel any or all of the
31 insurance contracts listed in the agreement as provided by Section
32 651.161. (V.T.I.C. Art. 24.17, Sec. (b) (part).)

33 Source Law

34 (b) A premium finance agreement may contain a
35 power of attorney enabling the premium finance company
36 to cancel any insurance contract or contracts listed
37 in the agreement. . . .

38 Revised Law

39 Sec. 651.161. CANCELLATION OF INSURANCE CONTRACT. (a) An
40 insurance premium finance company may not cancel an insurance

1 contract listed in a premium finance agreement except as provided
2 by this section for an insured's failure to make a payment at the
3 time and in the amount provided in the agreement.

4 (b) The insurance premium finance company must mail to the
5 insured a written notice that the company will cancel the insurance
6 contract because of the insured's default in payment unless the
7 default is cured at or before the time stated in the notice. The
8 stated time may not be earlier than the 10th day after the date the
9 notice is mailed.

10 (c) The insurance premium finance company must also mail a
11 copy of the notice to the insurance agent or broker identified in
12 the premium finance agreement.

13 (d) After the time stated in the notice required by
14 Subsection (b), the insurance premium finance company may cancel
15 each applicable insurance contract by mailing a notice of
16 cancellation to the insurer. Each insurance contract shall be
17 canceled as if the insured had canceled the contract, except that
18 the return of a canceled contract is not required.

19 (e) The insurance premium finance company must also mail a
20 notice of cancellation to:

21 (1) the insured at the insured's last known address;
22 and

23 (2) the insurance agent or broker identified in the
24 premium finance agreement.

25 (f) A statutory, regulatory, or contractual restriction
26 that provides that an insurance contract may not be canceled unless
27 notice is given to a governmental agency, mortgagee, or other third
28 party applies to a cancellation under this section. The insurer
29 shall:

30 (1) give the prescribed notice on behalf of the
31 insurer or the insured to each governmental agency, mortgagee, or
32 other third party on or before the second business day after the
33 date the insurer receives the notice of cancellation from the
34 insurance premium finance company; and

1 (2) determine the effective date of cancellation,
2 taking into consideration the number of days' notice required to
3 complete the cancellation. (V.T.I.C. Art. 24.17, Secs. (b) (part),
4 (c), (d), (e).)

5 Source Law

6 (b) . . . An insurance contract or contracts
7 may not be canceled by the premium finance company
8 unless the cancellation is effectuated in accordance
9 with this section.

10 (c) If the insured fails to make the payments at
11 the time and in the amount provided in the premium
12 finance agreement, the premium finance company shall
13 mail to the insured a written notice of the intent of
14 the premium finance company to cancel the insurance
15 contract because of the default in payments by the
16 insured unless the default in payments is cured within
17 a time certain stated in the notice. That time may not
18 be earlier than the 10th day after the date on which
19 the written notice was mailed. The premium finance
20 company shall also mail a copy of the notice to the
21 insurance agent or insurance broker indicated on the
22 premium finance agreements.

23 (d) After expiration of the period given to cure
24 the default, the premium finance company may cancel
25 the insurance contract or contracts by mailing to the
26 insurer a notice of cancellation. The insurance
27 contract shall be canceled as if the notice of
28 cancellation had been submitted by the insured, but
29 without requiring the return of the insurance contract
30 or contracts. The premium finance company shall also
31 mail a notice of cancellation to the insured at the
32 insured's last known address and to the insurance agent
33 or insurance broker indicated on the premium finance
34 agreement.

35 (e) All statutory, regulatory, and contractual
36 restrictions providing that the insurance contract may
37 not be canceled unless notice is given to a
38 governmental agency, mortgagee, or other third party
39 apply where cancellation is effected under this
40 section. The insurer shall give the prescribed notice
41 on behalf of itself or the insured to any governmental
42 agency, mortgagee, or other third party on or before
43 the second business day after the day on which it
44 receives the notice of cancellation from the premium
45 finance company and shall determine the effective date
46 of cancellation taking into consideration the number
47 of days' notice required to complete the cancellation.

48 Revised Law

49 Sec. 651.162. RETURN OF UNEARNED PREMIUMS AND
50 COMMISSIONS. (a) This section applies only to a premium finance
51 agreement that contains an assignment or power of attorney for the
52 benefit of the insurance premium finance company.

53 (b) If an insurance contract listed in a premium finance
54 agreement is canceled, the insurer shall return all unearned

1 premiums that are due under the contract directly to the insurance
2 premium finance company before the 61st day after the cancellation
3 date.

4 (c) The insurer may deduct from the unearned premiums
5 returned to the insurance premium finance company the amount of any
6 unearned commission due from the agent writing the insurance if the
7 insurer notifies the agent to return the unearned commission to the
8 insurance premium finance company. If the agent does not return the
9 unearned commission to the insurance premium finance company before
10 the 91st day after the cancellation date, the insurer shall remit
11 the unearned commission to the insurance premium finance company
12 before the 121st day after the cancellation date.

13 (d) Notwithstanding Subsections (a)-(c), an agent is liable
14 for the return of unearned commissions on an insurance contract
15 written through the Texas Windstorm Insurance Association, the
16 Texas Automobile Insurance Plan Association, or the Texas Medical
17 Liability Insurance Underwriting Association. An agent placing
18 business through one of those plans shall return the unearned
19 commissions to the insurance premium finance company before the
20 61st day after the date the agent is notified of the cancellation.

21 (e) An insurer, other than the Texas Windstorm Insurance
22 Association, the Texas Automobile Insurance Plan Association, or
23 the Texas Medical Liability Insurance Underwriting Association,
24 may return the unearned premiums to the producing agent. The
25 insurer remains liable and shall remit the unearned premiums to the
26 insurance premium finance company before the 121st day after the
27 cancellation date if:

28 (1) the producing agent does not return the unearned
29 premiums to the insurance premium finance company before the 91st
30 day after the cancellation date; and

31 (2) the insurance premium finance company complied
32 with Section 651.165.

33 (f) If the insurance premium finance company failed to
34 comply with Section 651.165, the insurer, including the Texas

1 Windstorm Insurance Association, the Texas Automobile Insurance
2 Plan Association, and the Texas Medical Liability Insurance
3 Underwriting Association, may comply with its legal duty to return
4 the unearned premiums due under the insurance contract to the
5 insurance premium finance company by returning those unearned
6 premiums to the producing agent.

7 (g) If the crediting of return premiums to the account of an
8 insured results in a surplus over the amount due from the insured,
9 the insurance premium finance company shall refund the excess to
10 the insured. If the amount of the excess is less than \$1, the
11 insured is not entitled to a refund. (V.T.I.C. Art. 24.17, Secs.
12 (f), (g).)

13 Source Law

14 (f) Whenever a financed insurance contract is
15 cancelled, and the premium finance agreement contains
16 an assignment or power of attorney for the benefit of
17 the premium finance company, the insurer shall return
18 whatever unearned premiums are due under the insurance
19 contract directly to the premium finance company
20 within 60 days after the policy cancellation date. The
21 insurer, however, may deduct from the unearned premium
22 returned to the premium finance company the amount of
23 unearned commission due from the agent or agency
24 writing the insurance if the insurer notifies such
25 agent or agency that such unearned commission should
26 be returned to the premium finance company. The
27 insurer shall remit the unearned commission to the
28 premium finance company within 120 days of the policy
29 cancellation date if the agent has not returned the
30 same to the premium finance company within 90 days
31 after the policy cancellation date.

32 Provided, however, agents or agencies shall be
33 liable for the return of unearned commissions on
34 policies written through the Texas Windstorm Insurance
35 Association, the Texas Automobile Insurance Plan, and
36 the Texas Medical Liability Insurance Underwriting
37 Association. Agents or agencies placing business
38 through these plans shall return the unearned
39 commissions to the premium finance company within 60
40 days after the agent or agency has been notified of the
41 cancellation.

42 The insurer, except the Texas Windstorm Insurance
43 Association, the Texas Automobile Insurance Plan, and
44 the Texas Medical Liability Insurance Underwriting
45 Association, may return the unearned premiums to the
46 producing agent or agency; however, the insurer shall
47 remain liable and remit to the premium finance company
48 within 120 days of the policy cancellation date if the
49 producing agent or agency does not return the unearned
50 premiums to the premium finance company within 90 days
51 after the policy cancellation date, provided the
52 premium finance company complied with the provisions
53 of Article 24.22 herein. In the event the premium
54 finance company fails to comply with the provisions in

1 Article 24.22 herein, the insurer, including the Texas
2 Windstorm Insurance Association, the Texas Automobile
3 Insurance Plan, and the Texas Medical Liability
4 Insurance Underwriting Association, may satisfy any
5 legal obligations it has to return the unearned
6 premiums due under the insurance contract to the
7 insurance premium finance company or returning said
8 unearned premiums to the producing agent or agency.

9 (g) In the event that the crediting of return
10 premiums to the account of the insured results in a
11 surplus over the amount due from the insured, the
12 premium finance company shall refund the excess to the
13 insured. No refund is required if it amounts to less
14 than \$1.

15 Revisor's Note

16 Section (f), V.T.I.C. Article 24.17, provides
17 that under certain circumstances an insurer "may
18 satisfy any legal obligations it has to return the
19 unearned premiums due under [a canceled] insurance
20 contract to the insurance premium finance company or
21 returning said unearned premiums to the producing
22 agent or agency." The "or" between "company" and
23 "returning" appears to be a typographical error, and
24 the revised law substitutes "by" for "or." It is clear
25 from the context that the provision authorizes an
26 insurer to satisfy its obligation to return the
27 unearned premiums to the insurance premium finance
28 company by returning the premiums to the producing
29 agent or agency.

30 Revised Law

31 Sec. 651.163. ASSIGNMENT OF PREMIUM FINANCE
32 AGREEMENT. Unless the insured has notice of an actual or intended
33 assignment of a premium finance agreement, payment by an insured
34 under the agreement to the last known holder of the agreement is
35 binding on all subsequent holders or assignees. (V.T.I.C. Art.
36 24.18.)

37 Source Law

38 Art. 24.18. Unless the insured has notice of
39 actual or intended assignment of a premium finance
40 agreement, payment under the agreement by the insured
41 to the last known holder of the agreement is binding on
42 all subsequent holders or assignees.

1 Revised Law

2 Sec. 651.164. RESTRICTIONS ON PREMIUM FINANCE
3 AGREEMENTS. (a) A premium finance agreement may not contain any
4 provision under which, absent default by the insured, the insurance
5 premium finance company holding the agreement may arbitrarily or
6 without reasonable cause accelerate the maturity of all or any part
7 of the amount owing under the agreement.

8 (b) For purposes of Subsection (a), reasonable cause
9 includes a proceeding in bankruptcy, receivership, or insolvency
10 instituted by or against the insured or the insolvency of or
11 suspension of business or cessation of the right to engage in
12 business by an insurer writing policies that are financed for the
13 insured under the premium finance agreement.

14 (c) A license holder may not take:

15 (1) an instrument in which the insured waives any
16 right accruing to the insured under this chapter;

17 (2) an instrument that has not been fully completed
18 and executed by the insured;

19 (3) an assignment of wages as security for an
20 insurance premium finance agreement entered into under this
21 chapter;

22 (4) a lien on real property as security for a premium
23 finance agreement entered into under this chapter, except any lien
24 created by law on the recording of an abstract of judgment; or

25 (5) a confession of judgment or a power of attorney in
26 favor of the license holder or a third person to confess judgment or
27 to appear for an insured in a judicial proceeding. (V.T.I.C. Art.
28 24.19.)

29 Source Law

30 Art. 24.19. (a) A premium finance agreement may
31 not contain any provision by which, in the absence of
32 default of the insured, the premium finance company
33 holding the agreement may arbitrarily and without
34 reasonable cause accelerate the maturity of any part
35 or all of the amount owing thereunder. Reasonable
36 cause without limitation includes a proceeding in
37 bankruptcy, receivership, or insolvency being
38 instituted by or against the insured or the insolvency

1 of or suspension of business or cessation of the right
2 to conduct business by an insurance company writing
3 policies that are financed for the insured under the
4 premium finance agreement.

5 (b) A licensee may not take:

6 (1) any instrument in which the borrower
7 waives any right accruing to the borrower under this
8 chapter;

9 (2) any instrument that has not been fully
10 completed and executed by the insured;

11 (3) an assignment of wages as security for
12 any insurance premium finance agreement made under
13 this chapter;

14 (4) a lien on real estate as security for
15 any insurance premium finance agreement made under
16 this chapter, except such a lien as is created by law
17 on the recording of an abstract of judgment; or

18 (5) any confession of judgment or any
19 power of attorney running to the licensee or to any
20 third person to confess judgment or to appear for a
21 borrower in a judicial proceeding.

22 Revisor's Note

23 (1) Section (a), V.T.I.C. Article 24.19,
24 describes reasonable cause to include "without
25 limitation" several actions. The revised law omits
26 "without limitation" as unnecessary because Section
27 311.005(13), Government Code (Code Construction Act),
28 applicable to the revised law, provides that
29 "includes" and "including" are terms of enlargement
30 and not of limitation and do not create a presumption
31 that components not expressed are excluded.

32 (2) Section (b), V.T.I.C. Article 24.19, refers
33 to a "borrower." The revised law substitutes
34 "insured" for "borrower" because "insured" is the term
35 used in the other provisions of Article 24.19 and it is
36 clear that the article is intended to protect a person
37 who enters into a premium finance agreement with an
38 insurance premium finance company, i.e., an "insured."

39 Revised Law

40 Sec. 651.165. REQUIRED NOTICE OF CERTAIN PREMIUM FINANCE
41 AGREEMENTS. (a) An insurance premium finance company that enters
42 into a premium finance agreement that includes an assignment or
43 power of attorney shall notify the insurer or the Texas Windstorm
44 Insurance Association, the Texas Automobile Insurance Plan

1 Association, or the Texas Medical Liability Insurance Underwriting
2 Association whose premiums are being financed:

3 (1) of the existence of the agreement; and

4 (2) to whom the premium payment has been made.

5 (b) An insurance premium finance company shall notify and
6 fund all premiums to a county mutual insurance company unless the
7 insurance premium finance company is authorized in writing by the
8 county mutual insurance company to notify or fund an agent or
9 managing general agent.

10 (c) Notice required under this section must be made before
11 the 31st day after the date the premium finance agreement is
12 accepted by the insurance premium finance company. (V.T.I.C. Art.
13 24.22.)

14 Source Law

15 Art. 24.22. Any premium finance company which
16 enters into a premium finance agreement which includes
17 an assignment or power of attorney shall notify either
18 the insurer or the Texas Windstorm Insurance
19 Association, the Texas Automobile Insurance Plan, or
20 the Texas Medical Liability Insurance Underwriting
21 Association whose premiums are being financed of the
22 existence of such agreement and to whom the premium
23 payment has been made. Provided, however, the premium
24 finance company shall notify and fund all premiums to
25 county mutual insurance companies unless the premium
26 finance company is authorized in writing by the county
27 mutual to notify or fund an agent or managing general
28 agent. Notification shall be made within 30 days of
29 the date the agreement is accepted by the premium
30 finance company.

31 Revised Law

32 Sec. 651.166. TAKING, RECEIVING, OR CHARGING UNAUTHORIZED
33 AMOUNT. (a) Taking or receiving from an insured or the charging of
34 an insured by an insurance premium finance company of a charge
35 greater than authorized by this chapter does not invalidate:

36 (1) the premium finance agreement; or

37 (2) the principal balance payable under the agreement.

38 (b) An action described by Subsection (a) may be adjudged a
39 forfeiture of all charges that:

40 (1) are authorized under the premium finance
41 agreement; or

1 (2) the insured has agreed to pay.

2 (c) A person who pays an unauthorized charge or the person's
3 legal representative may bring an action against the insurance
4 premium finance company to recover twice the total amount of the
5 charge paid. The action must be brought within two years after the
6 date the unauthorized charge is paid. (V.T.I.C. Art. 24.08, Sec.
7 (b).)

8 Source Law

9 (b) A premium finance company's taking or
10 receiving from or charging an insured a greater charge
11 than authorized by this chapter does not invalidate
12 the premium finance agreement or the principal balance
13 payable under the agreement but may be adjudged a
14 forfeiture of all charges that the premium finance
15 agreement carries with it or that have been agreed to
16 be paid by an insured, the person paying the charge or
17 the person's legal representative may recover from the
18 premium finance agency twice the entire amount of the
19 charges paid if action is brought within two years
20 after the day on which the payment is made.

21 Revised Law

22 Sec. 651.167. EFFECT OF LICENSE REVOCATION, SUSPENSION, OR
23 SURRENDER ON PREMIUM FINANCE AGREEMENT. The revocation,
24 suspension, or surrender of a license does not affect the
25 obligation of an insured under a lawful premium finance agreement
26 previously acquired or held by the person whose license was
27 revoked, suspended, or surrendered. (V.T.I.C. Art. 24.05, Sec.
28 (d).)

29 Source Law

30 (d) A revocation, suspension, or surrender of
31 any license does not affect the obligation of any
32 insured under a lawful premium finance agreement
33 previously acquired or held by the licensee.

34 [Sections 651.168-651.200 reserved for expansion]

35 SUBCHAPTER E. DISCIPLINARY PROCEDURES AND PENALTIES; OFFENSES

36 Revised Law

37 Sec. 651.201. EXAMINATIONS AND INVESTIGATIONS OF LICENSE
38 HOLDERS. (a) The department may conduct an examination or
39 investigation that is necessary to determine whether a license
40 holder:

41 (1) is in compliance with this chapter; or

1 (2) has engaged in conduct that would warrant the
2 revocation or suspension of the license holder's license.

3 (b) The department or an authorized representative of the
4 department may:

5 (1) require the attendance of any person;

6 (2) examine the person under oath; and

7 (3) compel the production of any relevant book,
8 record, account, or document. (V.T.I.C. Art. 24.06, Sec. (a).)

9 Source Law

10 Art. 24.06. (a) The board may make examinations
11 or investigations necessary to determine whether a
12 licensee is in compliance with this chapter or whether
13 a licensee has conducted himself or herself so as to
14 justify the revocation of his or her license. The
15 board or its duly authorized representatives may
16 require the attendance of any person, may examine the
17 person under oath, and may compel the production of all
18 relevant books, records, accounts, and documents.

19 Revised Law

20 Sec. 651.202. CONFIDENTIALITY OF REPORTS AND RELATED
21 MATERIAL. (a) A report of an examination or investigation under
22 Section 651.201 and any correspondence or memoranda concerning or
23 arising from the examination or investigation:

24 (1) are confidential communications;

25 (2) are not subject to subpoena; and

26 (3) may not be made public, except in connection with a
27 hearing under Section 651.204 or an appearance in connection with
28 the hearing.

29 (b) Subsection (a) applies to an authenticated copy of a
30 report described by Subsection (a) in the possession of the
31 commissioner, the department, or a license holder.

32 (c) Information obtained in the course of an examination or
33 investigation may be made available to another governmental agency
34 if the information involves a matter within the scope or
35 jurisdiction of the agency. (V.T.I.C. Art. 24.06, Sec. (b).)

36 Source Law

37 (b) All reports of examinations or
38 investigations and all correspondence and memoranda
39 concerning or arising out of those examinations or

1 investigations, including any duly authenticated copy
2 or copies of those reports in the possession of any
3 licensee or the board, are confidential
4 communications, are not subject to subpoena, and may
5 not be made public, except in connection with a hearing
6 under Article 24.05 of this chapter and any appearance
7 in connection with such a hearing. Information
8 obtained in the course of these examinations or
9 investigations may be made available to other
10 governmental agencies when the information involves
11 matters within the scope or jurisdiction of those
12 agencies.

13 Revised Law

14 Sec. 651.203. HEARINGS AND INVESTIGATIONS; SUBPOENA
15 POWER. In conducting a hearing or investigation under this
16 chapter, the department or a person designated by the department
17 may:

- 18 (1) administer oaths;
19 (2) subpoena witnesses;
20 (3) take depositions of witnesses who reside outside
21 of this state in the manner provided for in a civil action in
22 district court; and
23 (4) pay to those witnesses a fee and mileage for
24 attendance as provided for a witness in a civil action in district
25 court. (V.T.I.C. Art. 24.07.)

26 Source Law

27 Art. 24.07. In conducting a hearing or
28 investigation under this chapter, the board or any
29 person duly designated by it may:

- 30 (1) subpoena witnesses;
31 (2) take depositions of witnesses residing
32 outside of the state in the manner provided for in
33 civil actions in district courts;
34 (3) pay to those witnesses the fees and
35 mileage for their attendance as provided for witnesses
36 in civil actions in district courts; and
37 (4) administer oaths.

38 Revised Law

39 Sec. 651.204. REVOCATION OR SUSPENSION OF LICENSE. After
40 notice and hearing, the department may revoke or suspend a license
41 if:

- 42 (1) the department finds:
43 (A) that the license holder has violated this
44 chapter or a rule adopted by the commissioner under this chapter; or
45 (B) the existence of a fact or condition that, if

1 the fact or condition existed at the time of the original
2 application for the license, clearly would have warranted the
3 refusal of the license; or

4 (2) the department learns from any source that the
5 license holder has failed to return all amounts due from an
6 insurance premium finance company to the person whose insurance
7 policy has been canceled as required by Section 651.162. (V.T.I.C.
8 Art. 24.05, Secs. (a), (b).)

9 Source Law

10 Art. 24.05. (a) After notice and hearing, the
11 board may revoke or suspend any license issued under
12 this chapter if it finds:

13 (1) that the licensee has violated this
14 chapter or any rule lawfully made by the board under
15 this chapter; or

16 (2) the existence of any fact or condition
17 that, if it had existed at the time of the original
18 application for the license, clearly would have
19 warranted the board to refuse to issue the license.

20 (b) The board, after notice and hearing, may
21 suspend or revoke a license if it learns from the
22 commissioner of insurance or from any other source
23 that the licensee has failed to return all amounts due
24 from the insurance premium finance company to the
25 person whose insurance policy has been canceled as
26 required by Section (g), Article 24.17 of this
27 chapter.

28 Revised Law

29 Sec. 651.205. ISSUANCE OF REVOCATION OR SUSPENSION
30 ORDER. If the department revokes or suspends a license, the
31 department shall:

32 (1) immediately issue in duplicate a written order of
33 revocation or suspension;

34 (2) file one copy of the order in the office of the
35 secretary of state; and

36 (3) mail one copy of the order to the license holder.
37 (V.T.I.C. Art. 24.05, Sec. (e).)

38 Source Law

39 (e) If the board revokes or suspends a license,
40 it shall immediately execute in duplicate a written
41 order to that effect and shall file one copy of that
42 order in the office of the secretary of state and mail
43 one copy to the licensee.

1 Revisor's Note

2 Section (e), V.T.I.C. Article 24.05, provides
3 that, if the board revokes or suspends a license, the
4 board "shall immediately execute . . . a written order
5 to that effect." The revised law substitutes "issue"
6 for "execute" because, in this context, the terms are
7 synonymous and "issue" is more commonly used in
8 licensing disciplinary provisions of other statutes.

9 Revised Law

10 Sec. 651.206. SURRENDER OF LICENSE; EFFECT. (a) A license
11 holder may surrender a license by delivering to the department
12 written notice that the license holder surrenders the license.

13 (b) The surrender of a license does not affect any civil or
14 criminal liability of the person for an act committed before the
15 surrender. (V.T.I.C. Art. 24.05, Sec. (c).)

16 Source Law

17 (c) Any licensee may surrender any license by
18 delivering to the board written notice that the
19 licensee surrenders the license. The surrender of a
20 license does not affect the licensee's civil or
21 criminal liability, if any, for acts committed before
22 the surrender.

23 Revised Law

24 Sec. 651.207. LICENSE REINSTATEMENT. The department may
25 reinstate a suspended license or issue a new license to a person
26 whose license has been revoked if no fact or condition exists that
27 clearly would have warranted the refusal to issue the license
28 originally. (V.T.I.C. Art. 24.05, Sec. (f).)

29 Source Law

30 (f) The board may reinstate a suspended license
31 or issue a new license to a person whose license has
32 been revoked if no fact or condition then exists that
33 clearly would have justified the board in refusing
34 originally to issue the license under this chapter.

35 Revised Law

36 Sec. 651.208. OFFENSE. (a) A person commits an offense if
37 the person:

38 (1) intentionally, knowingly, recklessly, or

1 negligently engages in the operation of an insurance premium
2 finance company and does not hold a license issued under this
3 chapter;

4 (2) intentionally, knowingly, recklessly, or
5 negligently violates this chapter;

6 (3) intentionally or knowingly omits to state a
7 material fact necessary to give the commissioner or the department
8 information lawfully required of the person; or

9 (4) refuses to permit an investigation or examination
10 authorized under this chapter.

11 (b) An offense under this section is a Class B misdemeanor.
12 (V.T.I.C. Art. 24.08, Sec. (a).)

13 Source Law

14 Art. 24.08. (a) (1) A person commits an
15 offense if the person:

16 (A) intentionally, knowingly,
17 recklessly, or negligently engages in the operation of
18 a premium finance company without first obtaining a
19 license;

20 (B) intentionally, knowingly,
21 recklessly, or negligently acts in violation of this
22 chapter;

23 (C) intentionally or knowingly omits
24 to state any material fact necessary to give the board
25 any information lawfully required of the person; or

26 (D) refuses to permit any lawful
27 investigation or examination under this chapter.

28 (2) An offense under this chapter is a
29 Class B misdemeanor.

30 Revised Law

31 Sec. 651.209. SANCTIONS; CEASE AND DESIST ORDERS. In
32 addition to each penalty provided by Sections 651.166 and 651.208,
33 the commissioner or a person designated by the commissioner may:

34 (1) order a sanction under Subchapter B, Chapter 82;

35 or

36 (2) issue a cease and desist order under Chapter 83.

37 (V.T.I.C. Art. 24.08, Sec. (c).)

38 Source Law

39 (c) In addition to the penalties set in
40 Subsections (a) and (b), the board or any person duly
41 designated by it may order sanctions as provided by
42 Section 7, Article 1.10, of this code and issue cease
43 and desist orders as provided by Article 1.10A of this
44 code.

1 [Chapters 652-700 reserved for expansion]

2 SUBTITLE F. INSURANCE FRAUD

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8 [Sections 701.004-701.050 reserved for expansion]

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13 [Sections 701.053-701.100 reserved for expansion]

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33 Sec. 701.154. DISCLOSURE OF INFORMATION TO PUBLIC 529

1 CHAPTER 701. INSURANCE FRAUD INVESTIGATIONS

2 SUBCHAPTER A. GENERAL PROVISIONS

3 Revised Law

4 Sec. 701.001. DEFINITIONS. In this chapter:

5 (1) "Authorized governmental agency" means:

6 (A) a municipal, county, or state law enforcement
7 agency of this state or another state or a law enforcement agency of
8 the United States; or

9 (B) the prosecuting attorney of a municipality,
10 county, or judicial district of this state or another state or the
11 prosecuting attorney of the United States.

12 (2) "Fraudulent insurance act" means an act that is a
13 violation of a penal law and is:

14 (A) committed or attempted while engaging in the
15 business of insurance;

16 (B) committed or attempted as part of or in
17 support of an insurance transaction; or

18 (C) part of an attempt to defraud an insurer.

19 (3) "Insurer" means a person who is engaged in the
20 business of insurance as a principal or agent. The term includes:

21 (A) an unauthorized insurer; and

22 (B) an entity that is self-insured and provides
23 health care benefits to the entity's employees.

24 (4) "Person" means an individual, corporation,
25 organization, governmental entity, business trust or another
26 trust, estate, partnership, joint venture, association, or any
27 other legal entity. (V.T.I.C. Art. 1.10D, Sec. 1(a).)

28 Source Law

29 Art. 1.10D

30 Sec. 1. (a) In this article:

31 (1) "Authorized governmental agency"
32 means:

33 (A) a duly constituted municipal,
34 county, or state law enforcement agency of this or
35 another state or a federal law enforcement agency; or

36 (B) the prosecuting attorney of any
37 municipality, county, or judicial district of this
38 state, another state, or of the United States.

39 (2) "Fraudulent insurance act" means any

1 act that is a violation of any penal law and that:
2 (A) is committed or attempted to be
3 committed while engaging in the business of insurance
4 or as part of or in support of an insurance
5 transaction; or

6 (B) is part of an attempt to defraud
7 an insurer.

8 (3) "Insurer" means a person engaged in
9 the business of insurance as a principal or agent. The
10 term includes an unauthorized insurer or any entity
11 that is self-insured and provides health care benefits
12 to its employees.

13 (4) "Person" means an individual,
14 corporation, organization, government or governmental
15 subdivision or agency, business trust, estate, trust,
16 partnership, joint venture, association, and any other
17 legal entity.

18 Revisor's Note

19 (1) Section 1(a), V.T.I.C. Article 1.10D,
20 refers to a "duly constituted" law enforcement agency.
21 The revised law omits "duly constituted" as
22 unnecessary because the phrase does not add to the
23 clear meaning of the law. An entity purporting to be a
24 law enforcement agency is not a law enforcement agency
25 if it is not duly constituted.

26 (2) Section 1(a), V.T.I.C. Article 1.10D,
27 defines "person" to include a "government or
28 governmental subdivision or agency." The revised law
29 states the substance of that provision in a more
30 concise way by substituting "governmental entity" for
31 "government or governmental subdivision or agency."

32 Revised Law

33 Sec. 701.002. BUSINESS OF INSURANCE. A person is engaged
34 in the business of insurance for purposes of this chapter if the
35 person performs any act described by Subchapter B, Chapter 101.
36 (V.T.I.C. Art. 1.10D, Sec. 1(b).)

37 Source Law

38 (b) A person is "engaged in the business of
39 insurance" for purposes of this article if the person
40 performs any act defined by Section 2, Article 1.14-1
41 of this code.

42 Revised Law

43 Sec. 701.003. EFFECT OF CHAPTER. This chapter does not:

44 (1) preempt the authority or relieve the duty of an

1 authorized governmental agency to investigate and prosecute
2 suspected criminal acts;

3 (2) prevent or prohibit a person from voluntarily
4 disclosing information to an authorized governmental agency;

5 (3) limit powers or duties granted to the commissioner
6 by any other law; or

7 (4) prohibit or limit the authority of an insurer to
8 conduct an independent investigation of suspected insurance claim
9 fraud. (V.T.I.C. Art. 1.10D, Secs. 2(e) (part); 7.)

10 Source Law

11 [Sec. 2]

12 (e) This section does not prohibit or limit the
13 authority of an insurer to conduct its own independent
14 investigation into a suspected case of insurance claim
15 fraud. . . .

16 Sec. 7. This article does not:

17 (1) preempt the authority or relieve the
18 duty of any authorized governmental agency to
19 investigate and prosecute suspected criminal acts;

20 (2) prevent or prohibit a person from
21 voluntarily disclosing any information to an
22 authorized governmental agency; or

23 (3) limit any powers or duties granted to
24 the commissioner or the board by this code or other
25 laws.

26 Revisor's Note

27 Section 7, V.T.I.C. Article 1.10D, refers to the
28 State Board of Insurance. Chapter 685, Acts of the
29 73rd Legislature, Regular Session, 1993, abolished the
30 board and transferred its functions to the
31 commissioner of insurance and the Texas Department of
32 Insurance. Throughout this chapter, references to the
33 board have been changed appropriately.

34 [Sections 701.004-701.050 reserved for expansion]

35 SUBCHAPTER B. REPORTING FRAUDULENT INSURANCE ACTS

36 Revised Law

37 Sec. 701.051. DUTY TO REPORT. (a) A person who determines
38 a fraudulent insurance act has been or is about to be committed
39 shall report the information in writing to the department or an
40 authorized governmental agency not later than the 30th day after

1 the date the person makes the determination.

2 (b) A report made to one authorized governmental agency or
3 the department constitutes notice to each other authorized
4 governmental agency and the department. (V.T.I.C. Art. 1.10D,
5 Secs. 4(a), (b).)

6 Source Law

7 Sec. 4. (a) If a person determines that a
8 fraudulent insurance act has been committed, or is
9 about to be committed, the person shall report the
10 information to the commissioner or board or to an
11 authorized governmental agency in writing not later
12 than the 30th day after the date of the determination.

13 (b) A report to one authorized governmental
14 agency or the department constitutes notice to all
15 authorized governmental agencies and to the
16 department.

17 Revised Law

18 Sec. 701.052. IMMUNITY FOR FURNISHING INFORMATION RELATING
19 TO A FRAUDULENT INSURANCE ACT. (a) A person is not liable in a
20 civil action, including an action for libel or slander, and a civil
21 action may not be brought against the person, for furnishing
22 information relating to a suspected, anticipated, or completed
23 fraudulent insurance act if the information is provided to:

24 (1) an authorized governmental agency or the
25 department;

26 (2) a law enforcement officer or an agent or employee
27 of the officer;

28 (3) the National Association of Insurance
29 Commissioners or an employee of the association;

30 (4) a state or federal governmental agency established
31 to detect and prevent fraudulent insurance acts or to regulate the
32 business of insurance or an employee of the agency; or

33 (5) a special investigative unit of an insurer,
34 including a person who contracts to provide special investigative
35 unit services to the insurer or an employee of the insurer who is
36 responsible for the investigation of suspected fraudulent
37 insurance acts.

38 (b) A person may furnish information as described in

1 Subsection (a) orally or in writing, including through publishing,
2 disseminating, or filing a bulletin or report.

3 (c) Subsection (a) does not apply to a person who acts with
4 malice, fraudulent intent, or bad faith.

5 (d) A person to whom Subsection (a) applies who prevails in
6 a civil action arising from furnishing information as described in
7 Subsection (a) is entitled to attorney's fees and costs.

8 (e) This section does not affect any common law or statutory
9 privilege or immunity.

10 (f) An insurer shall exercise reasonable care concerning
11 the accuracy of information conveyed to an authorized governmental
12 agency, the insurance fraud unit, or another insurer, person, or
13 entity. (V.T.I.C. Art. 1.10D, Secs. 6(a), (b), (c), (d), (e)
14 (part).)

15 Source Law

16 Sec. 6. (a) A person acting without malice,
17 fraudulent intent, or bad faith is not subject to
18 liability based on filing reports or furnishing,
19 orally or in writing, other information concerning
20 suspected, anticipated, or completed fraudulent
21 insurance acts if the reports or information are
22 provided to:

23 (1) a law enforcement officer or an agent
24 or employee of a law enforcement officer;

25 (2) the National Association of Insurance
26 Commissioners, a state or federal governmental agency
27 established to detect and prevent fraudulent insurance
28 acts or to regulate the business of insurance, or an
29 employee of that association or governmental agency;

30 (3) an authorized governmental agency or
31 the department; or

32 (4) a special investigative unit of an
33 insurer, including a person contracting to provide
34 special investigative unit services, or an employee of
35 an insurer who is responsible for the investigation of
36 suspected fraudulent insurance acts.

37 (b) A person to whom Subsection (a) of this
38 section applies or an employee or agent of such a
39 person when performing an authorized activity,
40 including the publication or dissemination of any
41 related bulletin or reports, and while acting without
42 malice, fraudulent intent, or bad faith, is not
43 subject to civil liability for libel, slander, or any
44 other relevant tort, and a civil cause of action of any
45 nature may not exist against that person based on those
46 activities.

47 (c) This section does not affect or modify any
48 common law or statutory privilege or immunity.

49 (d) A person to whom Subsection (a) of this
50 section applies or an employee or agent of such a
51 person is entitled to an award of attorney's fees and
52 costs if the person, employee, or agent is a prevailing

1 party in a civil cause of action for libel, slander, or
2 any other relevant tort based on activities performed
3 under Subsection (a) of this section.

4 (e) . . . An insurer must exercise reasonable
5 care concerning the accuracy of the information
6 conveyed to the insurance fraud unit, an authorized
7 governmental agency, other insurers, or other persons
8 or entities.

9 Revisor's Note

10 (1) Section 6(b), V.T.I.C. Article 1.10D,
11 refers to a person to whom Section 6(a) of the article
12 applies or "an employee or agent of such a person when
13 performing an authorized activity." Section 6(d),
14 V.T.I.C. Article 1.10D, refers to a person to whom
15 Section 6(a) of the article applies or "an employee or
16 agent of such a person." The revised law omits the
17 quoted phrases as unnecessary because an employee or
18 agent is included as a person to whom Section 6(a),
19 revised as Section 701.052(a), applies.

20 (2) Section 6(b), V.T.I.C. Article 1.10D,
21 refers to a civil cause of action "of any nature." The
22 revised law omits the quoted phrase as unnecessary
23 because the term "civil cause of action" impliedly
24 includes any kind of civil action unless otherwise
25 modified.

26 (3) Section 6(c), V.T.I.C. Article 1.10D,
27 provides that the section does not "affect or modify" a
28 common law or statutory privilege or immunity. The
29 revised law omits the reference to "modify" because
30 "modify" is included in the meaning of "affect."

31 [Sections 701.053-701.100 reserved for expansion]

32 SUBCHAPTER C. INVESTIGATIONS

33 Revised Law

34 Sec. 701.101. INSURANCE FRAUD UNIT. (a) The purpose of
35 the department's insurance fraud unit is to enforce laws relating
36 to fraudulent insurance acts.

37 (b) The insurance fraud unit may receive, review, and
38 investigate in a timely manner insurer antifraud reports submitted

1 under Chapter 704.

2 (c) The insurance fraud unit shall report annually to the
3 commissioner in writing regarding:

4 (1) the number of cases completed by the insurance
5 fraud unit; and

6 (2) recommendations for regulatory and statutory
7 responses to the types of fraudulent activities encountered by the
8 insurance fraud unit. (V.T.I.C. Art. 1.10D, Secs. 2(a); 3A.)

9 Source Law

10 Sec. 2. (a) The insurance fraud unit is created
11 in the Texas Department of Insurance to enforce laws
12 relating to fraudulent insurance acts.

13 Sec. 3A. (a) The insurance fraud unit may
14 receive, review and investigate in a timely manner
15 insurer antifraud reports submitted under Subchapter
16 K, Chapter 3, of this code.

17 (b) The insurance fraud unit shall report
18 annually in writing to the commissioner the number of
19 cases completed and any recommendations for new
20 regulatory and statutory responses to the types of
21 fraudulent activities encountered by the insurance
22 fraud unit.

23 Revisor's Note

24 Section 2(a), V.T.I.C. Article 1.10D, provides
25 that "[t]he insurance fraud unit is created in the
26 Texas Department of Insurance." The revised law omits
27 the reference to creating the insurance fraud unit as
28 executed.

29 Revised Law

30 Sec. 701.102. INVESTIGATION OF CERTAIN ACTS OF FRAUD. If
31 the commissioner has reason to believe a person has engaged in, is
32 engaging in, has committed, or is about to commit a fraudulent
33 insurance act or the offense of insurance fraud under Section
34 35.02(a), Penal Code, the commissioner may conduct any
35 investigation necessary inside or outside this state to:

36 (1) determine whether the act or offense occurred; or

37 (2) aid in enforcing laws relating to fraudulent
38 insurance acts or insurance fraud. (V.T.I.C. Art. 1.10D, Sec.
39 2(b).)

1 Source Law

2 (b) If the commissioner has reason to believe
3 that a person has engaged in or is engaging in an act or
4 practice that may constitute either a fraudulent
5 insurance act, as defined by Section 1(a)(2) of this
6 article, or insurance fraud under Section 35.02(a),
7 Penal Code, or has committed, or is about to commit, a
8 fraudulent insurance act or insurance fraud, the
9 commissioner may make any investigation necessary
10 inside or outside this state to determine whether or
11 not the act has occurred, or to aid in the enforcement
12 of the laws relating to fraudulent insurance acts or
13 insurance fraud.

14 Revisor's Note

15 Section 2(b), V.T.I.C. Article 1.10D, refers to
16 an "act or practice" that may constitute insurance
17 fraud. The revised law omits the reference to
18 "practice" because "practice" is included in the
19 meaning of "act."

20 Revised Law

21 Sec. 701.103. DISCIPLINARY ACTION; REPORT TO OTHER
22 AGENCIES. (a) The commissioner shall take appropriate
23 disciplinary action as provided by this code if the commissioner
24 believes a fraudulent insurance act has occurred. The commissioner
25 shall report information concerning the commissioner's belief that
26 a person has committed a fraudulent insurance act to an authorized
27 governmental agency.

28 (b) The commissioner shall:

29 (1) provide all material, documents, reports,
30 complaints, or other evidence to an authorized governmental agency
31 on request; and

32 (2) assist the authorized governmental agency as
33 requested. (V.T.I.C. Art. 1.10D, Secs. 2(c), (d).)

34 Source Law

35 (c) If the commissioner believes that a
36 fraudulent insurance act has occurred, the
37 commissioner shall take appropriate disciplinary
38 action as provided by this code. If the commissioner
39 believes that a person has committed a fraudulent
40 insurance act, the commissioner shall report the
41 information to an authorized governmental agency.

42 (d) The commissioner shall furnish all
43 materials, documents, reports, complaints, or other
44 evidence to any authorized governmental agency on
45 request and shall assist the authorized governmental

1 agency as requested.

2 Revised Law

3 Sec. 701.104. DEPARTMENT INVESTIGATORS. (a) The
4 commissioner may:

5 (1) employ investigators as necessary to enforce this
6 chapter; and

7 (2) commission those investigators as peace officers.

8 (b) If the commissioner commissions investigators as peace
9 officers, the commissioner shall appoint a chief investigator who:

10 (1) is commissioned as a peace officer; and

11 (2) is qualified by training and experience in law
12 enforcement to supervise, direct, and administer the activities of
13 the commissioned investigators.

14 (c) An investigator employed by the department as a peace
15 officer must meet the requirements for a peace officer under
16 Chapter 1701, Occupations Code. (V.T.I.C. Art. 1.10D, Sec. 2(f).)

17 Source Law

18 (f) The commissioner may employ investigators
19 as the commissioner considers necessary to enforce
20 this article and may commission those investigators as
21 peace officers. An investigator employed by the
22 department as a peace officer must meet the
23 requirements for peace officers imposed under Chapter
24 415, Government Code. If the commissioner elects to
25 commission peace officers, the commissioner shall
26 appoint a chief investigator who is commissioned as a
27 peace officer and who is qualified by training and
28 experience in law enforcement to supervise, direct,
29 and administer the activities of the commissioned
30 investigators.

31 Revisor's Note

32 Section 2(f), V.T.I.C. Article 1.10D, refers to
33 the requirements for a peace officer imposed under
34 Chapter 415, Government Code. That chapter was
35 recodified in 1999 as Chapter 1701, Occupations Code.
36 The revised law is drafted accordingly.

37 Revised Law

38 Sec. 701.105. ASSISTANCE FROM LAW ENFORCEMENT. An
39 investigator employed by the department may request assistance from
40 local law enforcement officers in conducting an investigation

1 authorized by this chapter. (V.T.I.C. Art. 1.10D, Sec. 2(g).)

2 Source Law

3 (g) An investigator employed by the department
4 may request the assistance of local law enforcement
5 officers in conducting an investigation authorized by
6 this article.

7 Revised Law

8 Sec. 701.106. SUBPOENA AUTHORITY. (a) The commissioner
9 may issue a subpoena to compel the attendance and testimony of a
10 witness or, except as provided by Subsection (b), the production of
11 materials relevant to an investigation under this chapter.

12 (b) A person is not required to produce an item subpoenaed
13 under Subsection (a) if the item can only be identified by writing
14 and executing a special computer program for that purpose.

15 (c) A person possessing materials located outside this
16 state that are requested by the commissioner may make the materials
17 available to the commissioner or a representative of the
18 commissioner for examination at the place where the materials are
19 located. The commissioner may designate a representative,
20 including an official of the state in which the materials are
21 located, to examine the materials. The commissioner may respond to
22 a similar request from an official of another state or the United
23 States. (V.T.I.C. Art. 1.10D, Secs. 3(a), (b).)

24 Source Law

25 Sec. 3. (a) The commissioner and at least one
26 member of the board may issue a subpoena and compel the
27 attendance and testimony of witnesses and the
28 production of materials relevant to an inquiry under
29 this article, except that a witness is not required to
30 produce any item that can be identified only through
31 the writing and execution of a special computer
32 program.

33 (b) A person with materials located outside this
34 state that are requested by the commissioner and at
35 least one member of the board may make the materials
36 available to the commissioner and the board member or a
37 representative of the commissioner and the board
38 member for examination at the place where the
39 materials are located. The commissioner and the board
40 member may designate representatives, including
41 officials of the state in which the materials are
42 located, to examine the materials and may respond to
43 similar requests from an official of another state or
44 of the United States.

1 Revisor's Note

2 (1) Section 3(a), V.T.I.C. Article 1.10D,
3 states that certain action may be taken by the
4 "commissioner and at least one member of the board."
5 As explained in the revisor's note to Section 701.003,
6 the State Board of Insurance was abolished in 1993.
7 For that reason, the revised law substitutes a
8 reference to the commissioner only for references to
9 powers granted jointly to the commissioner and a
10 member of the board.

11 (2) Section 3(a), V.T.I.C. Article 1.10D,
12 refers to an "inquiry" under this chapter. Throughout
13 this chapter, the revised law substitutes
14 "investigation" for "inquiry" for consistency of
15 terminology within the chapter.

16 Revised Law

17 Sec. 701.107. CERTAIN AGENCIES' DUTY TO PROVIDE
18 INFORMATION. (a) On the insurance fraud unit's request, an
19 authorized governmental agency or a state licensing agency shall
20 provide material, documents, reports, complaints, or other
21 evidence to the insurance fraud unit.

22 (b) Compliance with Subsection (a) by an authorized
23 governmental agency or a state licensing agency does not constitute
24 waiver of any otherwise applicable privilege or confidentiality
25 requirement. (V.T.I.C. Art.1.10D, Sec. 2(d-1) (part).)

26 Source Law

27 (d-1) An authorized governmental agency and any
28 state licensing agency shall furnish any materials,
29 documents, reports, complaints, or other evidence to
30 the insurance fraud unit on the request of the unit.
31 Compliance with this subsection by an authorized
32 governmental agency or state licensing agency does not
33 constitute waiver of any privilege or requirement of
34 confidentiality otherwise applicable. . . .

35 Revised Law

36 Sec. 701.108. INSURER'S DUTY TO PROVIDE INFORMATION. On
37 the written request of an authorized governmental agency, an

1 insurer shall provide to the agency any relevant information or
2 material relating to a matter under investigation. (V.T.I.C. Art.
3 1.10D, Sec. 4(c).)

4 Source Law

5 (c) On written request to any insurer by an
6 authorized governmental agency, the insurer shall
7 furnish to the authorized governmental agency any
8 relevant information or material relating to the
9 matter under investigation.

10 Revised Law

11 Sec. 701.109. REQUEST FOR INVESTIGATION BY INSURER. An
12 insurer must complete an investigation of suspected insurance claim
13 fraud and draft a report of the insurer's findings before
14 requesting that the commissioner conduct an investigation. The
15 insurer must submit the report and the related investigation file
16 to the commissioner as part of the insurer's request that the
17 commissioner conduct an investigation. (V.T.I.C. Art. 1.10D, Sec.
18 2(e) (part).)

19 Source Law

20 (e) . . . Before an insurer may request the
21 commissioner to conduct an investigation of suspected
22 claim fraud, the insurer must have completed its
23 investigation and drafted a report of its findings.
24 The insurer shall submit the report and the related
25 investigation file to the commissioner as part of the
26 insurer's request for investigation by the
27 commissioner.

28 [Sections 701.110-701.150 reserved for expansion]

29 SUBCHAPTER D. INSURANCE FRAUD INFORMATION; CONFIDENTIALITY

30 Revised Law

31 Sec. 701.151. CONFIDENTIALITY OF DEPARTMENT
32 INFORMATION. (a) Information or material acquired by the
33 department that is relevant to an investigation by the insurance
34 fraud unit is not a public record for the period the commissioner
35 considers reasonably necessary to:

- 36 (1) complete the investigation;
- 37 (2) protect the person under investigation from
38 unwarranted injury; or
- 39 (3) serve the public interest.

1 (b) The information or material is not subject to a subpoena
2 by another governmental entity, other than a grand jury subpoena,
3 until:

4 (1) the information or material is released for public
5 inspection by the commissioner; or

6 (2) after notice and a hearing a district court
7 determines that obeying the subpoena would not jeopardize the
8 public interest and any investigation by the commissioner.

9 (c) This section does not affect the conduct of a contested
10 case under Chapter 2001, Government Code. (V.T.I.C. Art. 1.10D,
11 Sec. 5(a).)

12 Source Law

13 Sec. 5. (a) Any information or material
14 acquired by the department that is relevant to an
15 inquiry by the insurance fraud unit is not a public
16 record for as long as the commissioner considers
17 reasonably necessary to complete the investigation,
18 protect the person under investigation from
19 unwarranted injury, or serve the public interest. The
20 information or material is not subject to a subpoena by
21 another governmental entity, except a valid grand jury
22 subpoena, until released for public inspection by the
23 commissioner or, after notice and a hearing, a
24 district court determines that the public interest and
25 any investigation by the commissioner would not be
26 jeopardized by obeying the subpoena. This subsection
27 does not affect the conduct of contested cases under
28 the Administrative Procedure and Texas Register Act
29 (Article 6252-13a, Vernon's Texas Civil Statutes).

30 Revisor's Note

31 (1) Section 5(a), V.T.I.C. Article 1.10D,
32 refers to a "valid" grand jury subpoena. The revised
33 law omits the reference to "valid" because, in
34 context, it does not add to clear meaning. An invalid
35 subpoena is not a subpoena.

36 (2) Section 5(a), V.T.I.C. Article 1.10D,
37 refers to the Administrative Procedure and Texas
38 Register Act (Article 6252-13a, Vernon's Texas Civil
39 Statutes). The relevant parts of the Administrative
40 Procedure Act were codified in 1993 as Chapter 2001,
41 Government Code. The revised law is drafted
42 accordingly.

1 Revised Law

2 Sec. 701.152. CONFIDENTIALITY OF AUTHORIZED GOVERNMENTAL
3 AGENCY INFORMATION. Information or material acquired under this
4 chapter by an authorized governmental agency is privileged and is
5 not a public record. The information or material is not subject to
6 a subpoena, other than a grand jury subpoena, unless, after
7 reasonable notice to the insurer and agency and a hearing, a
8 district court determines that obeying the subpoena would not
9 jeopardize the public interest and any investigation by the agency.
10 (V.T.I.C. Art. 1.10D, Sec. 5(b) (part).)

11 Source Law

12 (b) Any information or material acquired under
13 this article by an authorized governmental agency is
14 privileged and is not a part of any public
15 record. . . . The information or material is not
16 subject to a subpoena, except a valid grand jury
17 subpoena, unless, after reasonable notice to the
18 insurer and authorized governmental agency and after a
19 hearing, a district court determines that the public
20 interest and any investigation by the authorized
21 governmental agency will not be jeopardized by obeying
22 the subpoena.

23 Revisor's Note

24 Section 5(b), V.T.I.C. Article 1.10D, refers to a
25 "valid" grand jury subpoena. The revised law omits the
26 reference to "valid" for the reason stated in Revisor's
27 Note (1) to Section 701.151.

28 Revised Law

29 Sec. 701.153. DISCLOSURE OF INFORMATION TO CERTAIN
30 AGENCIES. An authorized governmental agency may release to
31 another authorized governmental agency or the department and the
32 department may release to an authorized governmental agency
33 information or material provided under this chapter. (V.T.I.C.
34 Art. 1.10D, Sec. 5(c).)

35 Source Law

36 (c) An authorized governmental agency or the
37 department provided with information or material may
38 release it to any other authorized governmental agency
39 or the department.

1 Revised Law

2 Sec. 701.154. DISCLOSURE OF INFORMATION TO PUBLIC. (a)
3 Except as otherwise provided by law, an authorized governmental
4 agency or an insurer that possesses or receives information or
5 material under this chapter may not release that information or
6 material to the public.

7 (b) Information provided under this chapter by an insurer to
8 the insurance fraud unit or an authorized governmental agency is
9 not subject to public disclosure. The information may be used by
10 the insurance fraud unit or authorized governmental agency only in
11 performing duties described by this chapter.

12 (c) Notwithstanding Section 701.151, the commissioner may
13 not release evidence obtained under Section 701.107 for public
14 inspection if releasing the evidence would violate a privilege held
15 by or a confidentiality requirement imposed on the agency from
16 which the evidence was obtained. (V.T.I.C. Art. 1.10D, Secs.
17 2(d-1) (part); 5(b) (part); 6(e) (part).)

18 Source Law

19 [Sec. 2]
20 (d-1) . . . Notwithstanding Section 5(a) of
21 this article, the commissioner may not release
22 evidence obtained under this subsection for public
23 inspection if release of the evidence would violate a
24 privilege held by or a requirement of confidentiality
25 imposed on the agency from which the evidence was
26 obtained.

27 [Sec. 5]
28 (b) . . . Except as otherwise provided by law,
29 an authorized governmental agency or an insurer that
30 possesses or receives any information or material
31 under this article may not release it to the
32 public. . . .

33 [Sec. 6]
34 (e) Information provided herein by an insurer to
35 the insurance fraud unit and/or an authorized
36 governmental agency shall not be subject to public
37 disclosure. The information may be used by the
38 insurance fraud unit and/or governmental agency only
39 for the performance of its duties as described
40 herein. . . .

41 CHAPTER 702. MOTOR VEHICLE THEFT AND MOTOR VEHICLE

42 INSURANCE FRAUD REPORTING

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1 Sec. 702.002. INSURER'S DUTY TO PROVIDE INFORMATION 531
2 Sec. 702.003. INSURER'S DUTY TO NOTIFY GOVERNMENTAL
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4 Sec. 702.004. DISCLOSURE OF INFORMATION TO CERTAIN
5 AGENCIES 533
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7 Sec. 702.006. IMMUNITY FOR PROVIDING INFORMATION 534

8 CHAPTER 702. MOTOR VEHICLE THEFT AND MOTOR VEHICLE
9 INSURANCE FRAUD REPORTING

10 Revised Law

11 Sec. 702.001. DEFINITIONS. In this chapter:

12 (1) "Authorized governmental agency" means:

- 13 (A) the Department of Public Safety;
- 14 (B) a police department of a municipality;
- 15 (C) a sheriff's department;
- 16 (D) a criminal investigative department or
17 agency of the United States; or
- 18 (E) the prosecuting attorney of:
 - 19 (i) a municipality, judicial district, or
20 county of this state;
 - 21 (ii) the United States; or
 - 22 (iii) a judicial district of the United
23 States.

24 (2) "Insurer" means an insurer that is:

- 25 (A) authorized to write motor vehicle insurance
26 in this state; or
- 27 (B) liable for a loss due to motor vehicle theft
28 or motor vehicle insurance fraud. (V.T.I.C. Art. 21.78, Sec. 1.)

29 Source Law

30 Art. 21.78

31 Sec. 1. In this article:

- 32 (1) "Authorized governmental agency"
33 means:
 - 34 (A) the Department of Public Safety,
35 a police department of any city, town, or village, a
36 county sheriff's department, or any duly constituted
37 criminal investigative department or agency of the
38 United States; or

1 (B) the prosecuting attorney of any
2 city, town, village, judicial district, or county of
3 the state, or of the United States or any judicial
4 district of the United States.

5 (2) "Insurer" means any insurer admitted
6 in this state to write insurance for motor vehicles or
7 otherwise liable for any loss due to motor vehicle
8 theft or motor vehicle insurance fraud.

9 Revisor's Note

10 (1) Section 1, V.T.I.C. Article 21.78, refers to
11 a "city, town, or village." The revised law
12 substitutes the term "municipality" for "city, town,
13 or village" because "municipality" is the term used in
14 the Local Government Code.

15 (2) Section 1, V.T.I.C. Article 21.78, refers to
16 a "duly constituted" criminal investigative
17 department or agency. The revised law omits "duly
18 constituted" as unnecessary. A criminal investigative
19 department or agency is not a department or agency if
20 it is not duly constituted.

21 Revised Law

22 Sec. 702.002. INSURER'S DUTY TO PROVIDE INFORMATION. (a)
23 On the written request of an authorized governmental agency to an
24 insurer, the insurer or an agent authorized by the insurer to act on
25 the insurer's behalf shall release to the agency any relevant
26 information the insurer has that:

27 (1) is requested by the agency; and

28 (2) relates to a specific motor vehicle theft or motor
29 vehicle insurance fraud.

30 (b) In this section, relevant information includes:

31 (1) insurance policy information relevant to the
32 specific motor vehicle theft or motor vehicle insurance fraud under
33 investigation, including any application for the policy;

34 (2) available policy premium payment records;

35 (3) the history of previous claims made by the
36 insured; and

37 (4) information relating to the investigation of the
38 motor vehicle theft or motor vehicle insurance fraud, including

1 statements of any person, proofs of loss, and notices of loss.
2 (V.T.I.C. Art. 21.78, Sec. 2(a).)

3 Source Law

4 Sec. 2. (a) On written request to any insurer
5 by an authorized governmental agency, the insurer or
6 an agent authorized by an insurer to act on its behalf
7 must release to the authorized governmental agency any
8 relevant information that the authorized governmental
9 agency requests and that the insurer has relating to
10 any specific motor vehicle theft or motor vehicle
11 insurance fraud. Relevant information includes:

12 (1) insurance policy information relevant
13 to the specific motor vehicle theft or motor vehicle
14 insurance fraud under investigation, including any
15 application for the policy;

16 (2) policy premium payment records that
17 are available;

18 (3) history of previous claims made by the
19 insured; and

20 (4) information relating to the
21 investigation of the motor vehicle theft or motor
22 vehicle insurance fraud, including statements of any
23 person, proofs of loss, and notice of loss.

24 Revised Law

25 Sec. 702.003. INSURER'S DUTY TO NOTIFY GOVERNMENTAL
26 AGENCY. (a) An insurer or an agent authorized by an insurer to act
27 on the insurer's behalf shall notify an authorized governmental
28 agency if it:

29 (1) knows or reasonably believes it knows the identity
30 of a person who it has reason to believe committed a criminal or
31 fraudulent act relating to a motor vehicle theft or motor vehicle
32 insurance claim; or

33 (2) knows of a criminal fraudulent act relating to a
34 motor vehicle theft or motor vehicle insurance claim that it
35 reasonably believes has not been reported to an authorized
36 governmental agency.

37 (b) Notice provided under this section to one authorized
38 governmental agency is sufficient notice to each other authorized
39 governmental agency. This subsection does not affect the rights
40 and duties created under Section 702.002. (V.T.I.C. Art. 21.78,
41 Secs. 2(b), (c).)

42 Source Law

43 (b) An insurer or an agent authorized by an
44 insurer to act on its behalf shall notify an authorized

1 governmental agency if it:

2 (1) knows or reasonably believes it knows
3 the identity of a person whom it has reason to believe
4 committed a criminal or fraudulent act relating to a
5 motor vehicle theft or motor vehicle insurance claim;
6 or

7 (2) has knowledge of a criminal fraudulent
8 act relating to a motor vehicle theft or motor vehicle
9 insurance claim that is reasonably believed not to
10 have been reported to an authorized governmental
11 agency.

12 (c) Notice to any of the authorized governmental
13 agencies under this section is sufficient notice to
14 all authorized governmental agencies. This subsection
15 does not affect the rights and duties created under
16 Subsection (a) of this section.

17 Revised Law

18 Sec. 702.004. DISCLOSURE OF INFORMATION TO CERTAIN
19 AGENCIES. An authorized governmental agency provided information
20 under Section 702.002 or 702.003 may provide the information to
21 another authorized governmental agency. (V.T.I.C. Art. 21.78, Sec.
22 2(d).)

23 Source Law

24 (d) The authorized governmental agency provided
25 with information under this section may release or
26 provide the information to any other authorized
27 governmental agencies.

28 Revisor's Note

29 Section 2(d), V.T.I.C. Article 21.78, authorizes
30 certain governmental agencies to "release or provide"
31 information to certain other governmental agencies.
32 The revised law omits the reference to "release"
33 because "release" is included within the meaning of
34 "provide."

35 Revised Law

36 Sec. 702.005. INFORMATION PRIVILEGED. (a) Information
37 provided under this chapter is privileged and is not a public
38 record. Except as otherwise provided by law, an entity that
39 receives information provided under this chapter may not release
40 the information to the public.

41 (b) Evidence or information provided under this chapter is
42 not subject to a subpoena ad testificandum or a subpoena duces tecum
43 in a civil or criminal proceeding unless, after reasonable notice

1 to an insurer, agent authorized by an insurer to act on the
2 insurer's behalf, or authorized governmental agency that has an
3 interest in the information and after a hearing, a court determines
4 that obeying the subpoena would not jeopardize the public interest
5 and any ongoing investigation by the insurer, agent, or authorized
6 governmental agency. (V.T.I.C. Art. 21.78, Sec. 3.)

7 Source Law

8 Sec. 3. Any information furnished as provided
9 by this article is privileged and not a part of any
10 public record. Except as otherwise provided by law,
11 any authorized governmental agency, insurer, or an
12 agent authorized by an insurer to act on its behalf
13 that receives any information furnished as provided by
14 this article may not release the information to the
15 public. The evidence or information is not subject to
16 a subpoena ad testificandum or a subpoena duces tecum
17 in a civil or criminal proceeding unless, after
18 reasonable notice to any insurer, an agent authorized
19 by an insurer to act on its behalf, or an authorized
20 governmental agency that has an interest in the
21 information and after a hearing, a court determines
22 that the public interest and any ongoing investigation
23 by the authorized governmental agency, insurer, or an
24 agent authorized by an insurer to act on its behalf
25 will not be jeopardized by obedience to the subpoena.

26 Revised Law

27 Sec. 702.006. IMMUNITY FOR PROVIDING INFORMATION. (a) An
28 insurer or a person who provides information on an insurer's behalf
29 is not liable for damages in a civil action or subject to criminal
30 prosecution for oral or written statements made or any other action
31 taken necessary to provide information as required by this chapter.

32 (b) Subsection (a) does not apply to an insurer or person
33 who acts with malice or fraudulent intent. (V.T.I.C. Art. 21.78,
34 Sec. 4.)

35 Source Law

36 Sec. 4. In the absence of fraud or malice, an
37 insurer or a person who furnishes information on its
38 behalf is not liable for damages in a civil action or
39 subject to criminal prosecution for oral or written
40 statements made or any other action taken necessary to
41 supply information required pursuant to this action.

42 Revisor's Note

43 Section 4, V.T.I.C. Article 21.78, refers to
44 "information required pursuant to this action." The
45 revised law substitutes "information as required by

1 this chapter" for the quoted language because
2 providing information is required by the chapter, not
3 by any action taken by an insurer or other person.

4 CHAPTER 703. COVERED ENTITY'S ANTIFRAUD ACTION

5 SUBCHAPTER A. GENERAL PROVISIONS

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22 ASSET 542

23 CHAPTER 703. COVERED ENTITY'S ANTIFRAUD ACTION

24 SUBCHAPTER A. GENERAL PROVISIONS

25 Revised Law

26 Sec. 703.001. DEFINITION. In this chapter, "covered
27 entity" means a health maintenance organization or insurer
28 regulated by the department, including:

- 29 (1) a stock life, health, or accident insurance
30 company;
31 (2) a mutual life, health, or accident insurance
32 company;
33 (3) a stock fire or casualty insurance company;
34 (4) a mutual fire or casualty insurance company;

- 1 (5) a Mexican casualty insurance company;
- 2 (6) a Lloyd's plan;
- 3 (7) a reciprocal or interinsurance exchange;
- 4 (8) a fraternal benefit society;
- 5 (9) a title insurance company;
- 6 (10) an attorney's title insurance company;
- 7 (11) a stipulated premium company;
- 8 (12) a nonprofit legal services corporation;
- 9 (13) a statewide mutual assessment company;
- 10 (14) a local mutual aid association;
- 11 (15) a local mutual burial association;
- 12 (16) an association exempt under Section 887.102;
- 13 (17) a nonprofit hospital, medical, or dental service
14 corporation, including a corporation subject to Chapter 842;
- 15 (18) a county mutual insurance company; and
- 16 (19) a farm mutual insurance company. (V.T.I.C. Art.
17 21.79D, Sec. 1(2).)

18 Source Law

19 Art. 21.79D
20 Sec. 1. In this article:

21 (2) "Insurer" means an insurance company
22 regulated by the board, including any domestic or
23 foreign, stock and mutual life, health, or accident
24 insurance company; domestic or foreign, stock and
25 mutual, fire and casualty insurance company; Mexican
26 casualty company; domestic or foreign Lloyd's plan
27 insurer; domestic or foreign reciprocal or
28 interinsurance exchange; domestic or foreign
29 fraternal benefit society; domestic or foreign title
30 insurance company; attorney's title insurance company;
31 stipulated premium insurance company; nonprofit legal
32 service corporation; statewide mutual assessment
33 company; local mutual aid association; local mutual
34 burial association; an exempt association under
35 Article 14.17 of this code; nonprofit hospital,
36 medical, or dental service corporation including a
37 company subject to Chapter 20 of this code; health
38 maintenance organization; county mutual insurance
39 company; or farm mutual insurance company.

40 Revisor's Note

41 (1) Section 1(2), V.T.I.C. Article 21.79D,
42 provides that "insurer" means an insurance company
43 regulated by the board, meaning the Texas Department

1 of Insurance, including certain listed entities. The
2 revised law substitutes "covered entity" for "insurer"
3 because the definition includes a "health maintenance
4 organization," which is not a traditional insurer.
5 Consequently, "covered entity" is a more accurate
6 term. Similar changes necessary to reflect the
7 applicability to a health maintenance organization are
8 made throughout this chapter.

9 (2) Section 1(2), V.T.I.C. Article 21.79D,
10 provides that "insurer" means an insurance company
11 regulated by the board, meaning the Texas Department
12 of Insurance, including certain "domestic or foreign"
13 insurers. The revised law omits the reference to
14 "domestic or foreign" as unnecessary. The authority
15 of the department to regulate domestic and foreign
16 insurers is specified in other provisions of the code
17 and, because the revised law applies to all insurers
18 regulated by the department, it is not necessary to
19 distinguish between domestic and foreign insurers in
20 this section.

21 (3) Section 1(1), V.T.I.C. Article 21.79D,
22 defines "board" to mean the State Board of Insurance.
23 Chapter 685, Acts of the 73rd Legislature, Regular
24 Session, 1993, abolished the board and transferred its
25 functions to the commissioner of insurance and the
26 Texas Department of Insurance. In the context of
27 Article 21.79D, it is appropriate to consider
28 references to the former board as references to the
29 department. For that reason, throughout this chapter,
30 references to the board have been changed to
31 "department" and the definition of "board" is omitted
32 from the revised law. The omitted law reads:

33 (1) "Board" means the State
34 Board of Insurance.

1 Revised Law

2 Sec. 703.002. RIGHT OF INTERVENTION. This chapter does not
3 affect the right of any person, including a state agency, to
4 intervene in an antifraud action brought under this chapter.
5 (V.T.I.C. Art. 21.79D, Sec. 6.)

6 Source Law

7 Sec. 6. This article does not affect the right of
8 any person, including a state agency, to intervene in
9 an antifraud action brought under this article.

10 [Sections 703.003-703.050 reserved for expansion]

11 SUBCHAPTER B. ANTIFRAUD ACTION; CERTIFICATION

12 Revised Law

13 Sec. 703.051. ANTIFRAUD ACTION AUTHORIZED. (a) A covered
14 entity acting alone or through a person, corporation, or legal
15 entity affiliated with the covered entity may bring an action in a
16 court, including a counter-action or cross-action, to:

17 (1) prevent a person from fraudulently engaging in the
18 business of insurance or the business of a health maintenance
19 organization in this state; or

20 (2) redress the effects of a person who has
21 fraudulently engaged in the business of insurance or the business
22 of a health maintenance organization in this state.

23 (b) An action may be brought under this section if:

24 (1) the acts of the person may adversely affect or have
25 adversely affected at least 10 residents of this state; and

26 (2) the department has not brought an antifraud action
27 in a court against the person.

28 (c) An action may be brought under this section regardless
29 of whether the covered entity is directly affected by the person's
30 acts. (V.T.I.C. Art. 21.79D, Sec. 2.)

31 Source Law

32 Sec. 2. An insurer acting alone or by and through
33 any affiliated person, corporation, or legal entity
34 may bring an action, counter-action, or cross-action
35 in a court of competent jurisdiction to prevent a
36 person from fraudulently engaging in the business of
37 insurance in this state or to redress the effects of a
38 person who has fraudulently engaged in the business of

1 insurance in this state, without regard to whether the
2 insurer is directly affected by the actions of the
3 person, if:

4 (1) the acts of the person may adversely
5 affect or have adversely affected at least 10 persons
6 who are citizens of this state; and

7 (2) the board has not commenced a court
8 antifraud action against the person.

9 Revisor's Note

10 (1) Section 2, V.T.I.C. Article 21.79D, refers
11 to certain proceedings in a court "of competent
12 jurisdiction." Throughout this chapter, the revised
13 law omits the quoted language as unnecessary because
14 the general laws of civil jurisdiction determine which
15 courts have jurisdiction over the matter. For
16 example, see Sections 24.007-24.011, Government Code,
17 for the general jurisdiction of district courts.

18 (2) Section 2, V.T.I.C. Article 21.79D, refers
19 to "citizens of this state." The revised law
20 substitutes "resident" for "citizen" because, in
21 context, "citizen" and "resident" are synonymous, and
22 "resident" is more commonly used.

23 Revised Law

24 Sec. 703.052. REQUEST FOR CERTIFICATION. A covered entity
25 may request the court to certify that the action is an antifraud
26 action under this chapter. (V.T.I.C. Art. 21.79D, Sec. 3(a).)

27 Source Law

28 Sec. 3. (a) An insurer may request a court of
29 competent jurisdiction to certify that an action is an
30 antifraud action under this article.

31 Revised Law

32 Sec. 703.053. NOTICE OF REQUEST FOR CERTIFICATION. (a)
33 When a covered entity files a request for certification, the
34 covered entity shall provide at least 10 days' notice of the request
35 to the department and the attorney general by serving each with a
36 copy of the request in the manner provided for service of notice
37 under Rule 21a, Texas Rules of Civil Procedure.

38 (b) The covered entity shall provide the notice regardless
39 of whether the department or the state is a party to the action.

1 (V.T.I.C. Art. 21.79D, Sec. 3(b).)

2 Source Law

3 (b) When the insurer files a request for
4 certification with the court, the insurer shall give
5 at least 10 days notice of the request to the board,
6 and to the attorney general, whether or not the board
7 or the state is a party to the action, by serving the
8 board and the state with a copy of the request for
9 certification of the action by the court in the manner
10 provided for service of notice pursuant to Rule 21a of
11 the Texas Rules of Civil Procedure.

12 Revised Law

13 Sec. 703.054. HEARING ON REQUEST FOR CERTIFICATION. As
14 soon as practicable after a covered entity files a request for
15 certification, the court shall hold a hearing to determine whether
16 the action is an antifraud action under this chapter. (V.T.I.C.
17 Art. 21.79D, Sec. 3(c).)

18 Source Law

19 (c) As soon as practicable after the request by
20 the insurer, the court shall hold a hearing to
21 determine if the action is an antifraud action under
22 this article.

23 Revised Law

24 Sec. 703.055. CERTIFICATION. The court shall certify that
25 the action is an antifraud action if the court determines that:

- 26 (1) the requirements of Section 703.051 are met; and
27 (2) the pleadings and evidence demonstrate that the
28 covered entity has a probable right of recovery. (V.T.I.C. Art.
29 21.79D, Sec. 3(d).)

30 Source Law

31 (d) The court shall certify that the action is
32 an antifraud action if the court determines that:
33 (1) the requirements of Section 2 of this
34 article for bringing an antifraud action are met; and
35 (2) the pleadings and evidence show that
36 the insurer has a probable right of recovery on the
37 action.

38 [Sections 703.056-703.100 reserved for expansion]

39 SUBCHAPTER C. EXPENSES OF ANTIFRAUD ACTION

40 Revised Law

41 Sec. 703.101. DETERMINATION OF EXPENSES. (a) The court
42 that certifies an action as an antifraud action by order may

1 determine the amount of reasonable and necessary expenses incurred
2 in bringing the action, including court costs, reasonable
3 attorney's fees, witness fees, fees of experts, and deposition
4 expenses.

5 (b) In making the determination, the court may consider the
6 contribution to the action of any person, including a state agency,
7 that has intervened in the action. (V.T.I.C. Art. 21.79D, Sec. 4.)

8 Source Law

9 Sec. 4. (a) A court that certifies that an
10 action is an antifraud action under this article may,
11 from time to time, enter orders that determine the
12 amount of reasonable and necessary expenses, including
13 court costs, reasonable attorney's fees, witness fees,
14 fees of experts, and deposition expenses incurred in
15 bringing the action.

16 (b) In making its determination under
17 Subsection (a) of this section, the court may consider
18 the contribution to the action of any person,
19 including a state agency, that has intervened in the
20 action.

21 Revisor's Note

22 Section 4, V.T.I.C. Article 21.79D, provides that
23 a court may enter certain orders "from time to time."
24 The revised law omits as unnecessary "from time to
25 time" because the power to take an action includes the
26 power to act "from time to time."

27 Revised Law

28 Sec. 703.102. DEDUCTION OR OFFSET FOR EXPENSES;
29 REIMBURSEMENT. (a) Subject to Subsection (b), a covered entity
30 has a deduction or offset against any obligation, assessment, or
31 debt owed by the covered entity to this state in the amount of the
32 reasonable and necessary expenses determined by the court order.

33 (b) The covered entity shall reimburse the state the amount
34 of any expenses actually recovered from the parties to the private
35 antifraud action under a final judgment awarding, wholly or partly,
36 expenses to or for the covered entity's benefit. The amount of
37 reimbursement may not exceed the actual amount of deductions or
38 offsets taken by the covered entity. (V.T.I.C. Art. 21.79D, Sec.
39 5(a) (part).)

1 Source Law

2 Sec. 5. (a) The reasonable and necessary
3 expenses incurred that are determined by orders of the
4 court constitute deductions or offsets against any
5 obligation, assessment, or debt of an insurer owed to
6 the state, provided, the insurer reimburses the state
7 in the amount of any expenses actually recovered from
8 the parties to the private antifraud action under a
9 final judgment awarding, in whole or in part, costs and
10 expenses to or for the benefit of the insurer. The
11 reimbursement may not exceed the actual amounts of
12 deductions or offsets taken by the insurer. . . .

13 Revisor's Note

14 Section 5(a), V.T.I.C. Article 21.79D, refers to
15 "costs and expenses." The revised law omits the
16 reference to "costs" because, in context, the term is
17 included within the meaning of "expenses." See
18 Section 4, V.T.I.C. Article 21.79D, revised as Section
19 703.101 of this chapter.

20 Revised Law

21 Sec. 703.103. ASSIGNMENT OF DEDUCTION OR OFFSET. The
22 covered entity may assign the covered entity's deduction or offset
23 to any other covered entity or reinsurer. (V.T.I.C. Art. 21.79D,
24 Sec. 5(a) (part).)

25 Source Law

26 (a) . . . The insurer may assign the
27 deductions or offsets to any other insurer or
28 reinsurer.

29 Revised Law

30 Sec. 703.104. TREATMENT OF DEDUCTION OR OFFSET AS ADMITTED
31 ASSET. A covered entity or a covered entity's assignee entitled to
32 an offset or deduction that has not been used may show, in the
33 covered entity's or assignee's books and records, the balance of the
34 deduction or offset as an admitted asset for any purpose. (V.T.I.C.
35 Art. 21.79D, Sec. 5(b).)

36 Source Law

37 (b) Until a deduction or offset is taken, the
38 insurer or its assignee entitled to the offset or
39 deduction may reflect the balance of the deduction or
40 offset in its books and records as an admitted asset
41 for any purpose.

1 Revisor's Note
2 (End of Chapter)

3 V.T.I.C. Article 21.79D was enacted by Chapter
4 1026, Acts of the 71st Legislature, Regular Session,
5 1989. Section 3 of that act provided that the article
6 applied to certain actions commenced before the
7 effective date of the act. In Durish v. Texas State
8 Board of Insurance, 817 S.W.2d 764 (Tex.
9 App.--Texarkana 1991, no writ), the court of appeals
10 held the article to be void as a violation of the
11 retroactive law prohibition of Section 16, Article I,
12 Texas Constitution. The opinion of the court of
13 appeals does not discuss whether the provision of
14 Chapter 1026 that applied the article retroactively
15 should be treated as severable from the remaining
16 provisions enacted by that act (see Sections 311.032
17 and 312.013, Government Code). Because the supreme
18 court has not finally determined the constitutionality
19 of Article 21.79D, the article is revised as this
20 chapter.

21 CHAPTER 704. ANTIFRAUD PROGRAMS

22 SUBCHAPTER A. GENERAL PROVISIONS

23 Sec. 704.001. DEFINITION 544
24 Sec. 704.002. NOTICE RELATING TO FALSE OR FRAUDULENT CLAIMS
25 REQUIRED 546

26 [Sections 704.003-704.050 reserved for expansion]

27 SUBCHAPTER B. ANTIFRAUD PLANS

28 Sec. 704.051. ANTIFRAUD PLAN REQUIRED FOR CERTAIN PLAN
29 ISSUERS 547
30 Sec. 704.052. ANTIFRAUD PLAN REQUIREMENTS 547
31 Sec. 704.053. FILING OF ANTIFRAUD PLAN 547
32 Sec. 704.054. FRAUD AND ABUSE PLANS UNDER CERTAIN STATE
33 PROGRAMS; ENFORCEMENT 548

1 CHAPTER 704. ANTIFRAUD PROGRAMS

2 SUBCHAPTER A. GENERAL PROVISIONS

3 Revised Law

4 Sec. 704.001. DEFINITION. In this chapter, "plan issuer"
5 means:

6 (1) a health insurer, including a life, health, and
7 accident insurer, a health and accident insurer, a health
8 maintenance organization, and any other person operating under
9 Chapter 841, 842, 843, 884, 885, 982, or 1501 who is authorized to
10 issue, issue for delivery, or deliver insurance policies,
11 certificates, contracts, or evidences of coverage in this state;

12 (2) an approved nonprofit health corporation that
13 holds a certificate of authority issued under Chapter 844; or

14 (3) an insurer authorized by the department to write
15 workers' compensation insurance in this state. (V.T.I.C. Art.
16 3.97-1, Subdiv. (2).)

17 Source Law

18 Art. 3.97-1. In this subchapter:

19 (2) "Insurer" means:

20 (A) a health insurer, including a
21 life, health, and accident insurer, a health and
22 accident insurer, a health maintenance organization,
23 or any other person operating under the Texas Health
24 Maintenance Organization Act (Chapter 20A, Vernon's
25 Texas Insurance Code) or under Chapter 3, 10, 20, 22,
26 or 26 of this code who is authorized to issue, issue
27 for delivery, or deliver policies, certificates, or
28 contracts of insurance in this state;

29 (B) an approved nonprofit health
30 corporation that:

31 (i) is certified under Section
32 162.001(b), Occupations Code; and

33 (ii) holds a certificate of
34 authority issued by the commissioner under Article
35 21.52F of this code; or

36 (C) an insurer authorized by the
37 department to write workers' compensation insurance in
38 this state.

39 Revisor's Note

40 (1) Subdivision (1), V.T.I.C. Article 3.97-1,
41 defines "health care provider." The revised law omits
42 the definition as unnecessary because the defined term
43 is not used elsewhere in V.T.I.C. Subchapter K,

1 Chapter 3, revised as this chapter. The omitted
2 definition reads:

3 (1) "Health care provider"
4 means a person who furnishes services under
5 a license, certificate, registration, or
6 other authority issued by this state or
7 another state to diagnose, prevent,
8 alleviate, or cure a human illness or
9 injury.

10 (2) Subdivision (2), V.T.I.C. Article 3.97-1,
11 defines "insurer" to include entities such as health
12 maintenance organizations that are not traditional
13 insurers. Consequently, "plan issuer" is a more
14 accurate term than "insurer," and throughout this
15 chapter, the revised law substitutes "plan issuer" for
16 "insurer." In addition, the revised law adds a
17 reference to "evidences of coverage" to the list of
18 documents issued by a plan issuer for clarity because
19 that is the document issued by a health maintenance
20 organization.

21 (3) Subdivision (2)(A), V.T.I.C. Article
22 3.97-1, refers to Chapter 3 of the Insurance Code. The
23 relevant portions of Chapter 3, relating to life,
24 health, or accident insurers, are revised in Chapters
25 841 and 982 of this code. The revised law is drafted
26 accordingly.

27 (4) Subdivision (2)(B), V.T.I.C. Article
28 3.97-1, refers to an approved nonprofit health
29 corporation that "is certified under Section
30 162.001(b), Occupations Code," and holds a certificate
31 of authority "issued by the commissioner under Article
32 21.52F of this code." The reference to certification
33 under Section 162.001(b), Occupations Code, is
34 unnecessary because V.T.I.C. Article 21.52F, revised
35 as Chapter 844 of this code, requires an approved
36 nonprofit corporation to be certified under Section
37 162.001, Occupations Code, as a condition of holding a

1 certificate of authority. The reference to the
2 commissioner issuing the certificate of authority is
3 also unnecessary because Article 21.52F, as revised,
4 requires the commissioner to issue the certificate of
5 authority.

6 Revised Law

7 Sec. 704.002. NOTICE RELATING TO FALSE OR FRAUDULENT CLAIMS
8 REQUIRED. (a) A plan issuer who provides a form for a person to
9 make a claim against or to give notice of the person's intent to
10 make a claim against a policy, certificate, contract, or evidence
11 of coverage issued by the issuer must include on the form, in
12 comparative prominence with the other content on the form, a
13 statement that is substantially similar to the following: "Any
14 person who knowingly presents a false or fraudulent claim for the
15 payment of a loss is guilty of a crime and may be subject to fines
16 and confinement in state prison."

17 (b) This section does not apply to a form provided to make a
18 claim against a policy issued by a reinsurer. (V.T.I.C. Art.
19 3.97-2.)

20 Source Law

21 Art. 3.97-2. (a) If an insurer provides a form
22 for a person to use to make a claim against a policy
23 issued by the insurer or to give notice of a person's
24 intent to make a claim against a policy issued by the
25 insurer, the insurer shall provide on that form, in
26 comparative prominence with the other content on the
27 form, a statement substantially similar to the
28 following: "Any person who knowingly presents a false
29 or fraudulent claim for the payment of a loss is guilty
30 of a crime and may be subject to fines and confinement
31 in state prison."

32 (b) This section does not apply to a claim made
33 against a policy issued by a reinsurer.

34 Revisor's Note

35 Section (a), V.T.I.C. Article 3.97-2, refers to a
36 "policy" issued by an insurer. As explained in
37 Revisor's Note (2) to Section 704.001, the revised law
38 substitutes "plan issuer" for "insurer." The revised
39 law also substitutes "policy, certificate, contract,
40 or evidence of coverage" for "policy" to more

1 accurately reflect the documents issued by a plan
2 issuer and for consistency with terminology used in
3 Subdivision (2), V.T.I.C. Article 3.97-1, revised as
4 Section 704.001.

5 [Sections 704.003-704.050 reserved for expansion]

6 SUBCHAPTER B. ANTIFRAUD PLANS

7 Revised Law

8 Sec. 704.051. ANTIFRAUD PLAN REQUIRED FOR CERTAIN PLAN
9 ISSUERS. A plan issuer who collects direct written premium shall
10 adopt an antifraud plan under this subchapter. (V.T.I.C. Art.
11 3.97-3, Sec. (a) (part).)

12 Source Law

13 Art. 3.97-3. (a) An insurer who collects direct
14 written premium shall adopt an antifraud plan under
15 this article. . . .

16 Revised Law

17 Sec. 704.052. ANTIFRAUD PLAN REQUIREMENTS. An antifraud
18 plan adopted by a plan issuer under this subchapter must include a
19 description of the issuer's procedures for:

20 (1) detecting and investigating possible fraudulent
21 insurance acts; and

22 (2) reporting possible fraudulent insurance acts to
23 the insurance fraud unit. (V.T.I.C. Art. 3.97-3, Sec. (a) (part).)

24 Source Law

25 (a) [An insurer who collects direct written
26 premium shall adopt an antifraud plan under this
27 article.] . . . The plan must include:

28 (1) a description of the insurer's
29 procedures for detecting and investigating possible
30 fraudulent insurance acts; and

31 (2) a description of the insurer's
32 procedures for reporting possible fraudulent
33 insurance acts to the insurance fraud unit.

34 Revised Law

35 Sec. 704.053. FILING OF ANTIFRAUD PLAN. A plan issuer may
36 annually file the issuer's antifraud plan adopted under this
37 subchapter with the insurance fraud unit. (V.T.I.C. Art. 3.97-3,
38 Sec. (a) (part).)

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Source Law

(a) [An insurer . . . shall adopt an antifraud plan under this article.] The insurer may annually file that plan with the insurance fraud unit. . . .

Revised Law

Sec. 704.054. FRAUD AND ABUSE PLANS UNDER CERTAIN STATE PROGRAMS; ENFORCEMENT. (a) A fraud and abuse plan put in place by a plan issuer participating in the Medicaid STAR or STAR + Plus program or the child health plan program under Chapter 62, Health and Safety Code, and approved by a health and human services agency meets the requirements of this subchapter.

(b) If a plan issuer described by Subsection (a) is required by law to report possible fraudulent insurance acts to a health and human services agency or the office of the attorney general, the issuer is not required to report those acts to the insurance fraud unit.

(c) The insurance fraud unit, the office of the attorney general, and the health and human services agencies shall coordinate enforcement efforts with respect to fraudulent insurance acts covered by this chapter relating to the Medicaid program or the child health plan program. (V.T.I.C. Art. 3.97-3, Secs. (b), (c).)

Source Law

(b) If an insurer participating in the STAR or STAR + Plus Medicaid program, or the state child health plan under Chapter 62, Health and Safety Code, has in place a fraud and abuse plan approved by a health and human services agency, such plan shall be deemed to meet the requirements of this subchapter. If such insurer is required by law to report possible fraudulent insurance acts to a health and human services agency and/or the Office of Attorney General, such insurer shall not be required to also report such acts to the insurance fraud unit.

(c) The health and human services agencies, the Office of Attorney General, and the insurance fraud unit shall coordinate enforcement efforts relating to acts covered by this subchapter that occur in relation to the state Medicaid program or state child health plan program.

CHAPTER 705. MISREPRESENTATIONS BY POLICYHOLDERS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 705.001. DEFINITION. 549

1 Sec. 705.002. APPLICABILITY OF SUBCHAPTER 550

2 Sec. 705.003. POLICY PROVISION: MISREPRESENTATION IN PROOF

3 OF LOSS OR DEATH 550

4 Sec. 705.004. POLICY PROVISION: MISREPRESENTATION IN POLICY

5 APPLICATION 551

6 Sec. 705.005. NOTICE TO INSURED OF MISREPRESENTATIONS 552

7 [Sections 705.006-705.050 reserved for expansion]

8 SUBCHAPTER B. SPECIAL PROVISIONS RELATED TO LIFE, ACCIDENT, AND

9 HEALTH INSURANCE POLICIES

10 Sec. 705.051. IMMATERIAL MISREPRESENTATION IN LIFE,

11 ACCIDENT, OR HEALTH INSURANCE APPLICATION. . . 554

12 [Sections 705.052-705.100 reserved for expansion]

13 SUBCHAPTER C. SPECIAL PROVISIONS RELATED TO LIFE INSURANCE

14 POLICIES

15 Sec. 705.101. DEFINITION. 554

16 Sec. 705.102. APPLICABILITY OF SUBCHAPTER 555

17 Sec. 705.103. DOCUMENTS TO ACCOMPANY POLICY 555

18 Sec. 705.104. MISREPRESENTATION IN APPLICATION FOR LIFE

19 INSURANCE 556

20 Sec. 705.105. APPLICABILITY OF OTHER LAW. 556

21 CHAPTER 705. MISREPRESENTATIONS BY POLICYHOLDERS

22 SUBCHAPTER A. GENERAL PROVISIONS

23 Revised Law

24 Sec. 705.001. DEFINITION. In this subchapter, "insurance

25 policy" means a contract or policy of insurance. (V.T.I.C. Arts.

26 21.16 (part), 21.17 (part), 21.19 (part).)

27 Source Law

28 Art. 21.16. . . . contract or policy of

29 insurance

30 Art. 21.17. . . . insurance contracts or

31 policies

32 Art. 21.19. . . . contract or policy of

33 insurance

34 Revisor's Note

35 The definition of "insurance policy" is added to

36 the revised law for drafting convenience and to

1 eliminate frequent, unnecessary repetition of the
2 substance of the definition.

3 Revised Law

4 Sec. 705.002. APPLICABILITY OF SUBCHAPTER. Except as
5 provided by Section 705.005, this subchapter applies to each
6 insurance policy issued or contracted for in this state. (V.T.I.C.
7 Arts. 21.16 (part), 21.17 (part), 21.19 (part).)

8 Source Law

9 Art. 21.16. Any . . . policy of insurance issued
10 or contracted for in this State

11 Art. 21.17. . . . insurance . . . policies . . .
12 issued or contracted for in this State

13 Art. 21.19. Any . . . policy of insurance issued
14 or contracted for in this State

15 Revised Law

16 Sec. 705.003. POLICY PROVISION: MISREPRESENTATION IN PROOF
17 OF LOSS OR DEATH. (a) An insurance policy provision that states
18 that a misrepresentation, including a false statement, made in a
19 proof of loss or death makes the policy void or voidable:

20 (1) has no effect; and

21 (2) is not a defense in a suit brought on the policy.

22 (b) Subsection (a) does not apply if it is shown at trial
23 that the misrepresentation:

24 (1) was fraudulently made;

25 (2) misrepresented a fact material to the question of
26 the insurer's liability under the policy; and

27 (3) misled the insurer and caused the insurer to waive
28 or lose a valid defense to the policy. (V.T.I.C. Art. 21.19
29 (part).)

30 Source Law

31 Art. 21.19. Any provision in any . . . policy of
32 insurance . . . which provides that the same shall be
33 void or voidable, if any misrepresentations or false
34 statements be made in proofs of loss or of death, as
35 the case may be, shall be of no effect, and shall not
36 constitute any defense to any suit brought upon such
37 contract or policy, unless it be shown upon the trial
38 of such suit that the false statement made in such
39 proofs of loss or death was fraudulently made and
40 misrepresented a fact material to the question of the
41 liability of the insurance company upon the contract

1 of insurance sued on, and that the insurance company
2 was thereby misled and caused to waive or lose some
3 valid defense to the policy.

4 Revisor's Note

5 V.T.I.C. Article 21.19 refers to
6 "misrepresentations or false statements . . . made in
7 proofs of loss or of death." A false statement is a
8 type of misrepresentation; therefore, the revised law
9 substitutes "misrepresentation, including a false
10 statement" for the quoted phrase.

11 V.T.I.C. Article 21.19 also states that a "false
12 statement . . . misrepresented a fact material to the
13 question of the liability of the insurance company."
14 The revised law similarly substitutes
15 "misrepresentation" for "false statement."

16 Revised Law

17 Sec. 705.004. POLICY PROVISION: MISREPRESENTATION IN
18 POLICY APPLICATION. (a) An insurance policy provision that states
19 that false statements made in the application for the policy or in
20 the policy make the policy void or voidable:

21 (1) has no effect; and

22 (2) is not a defense in a suit brought on the policy.

23 (b) Subsection (a) does not apply if it is shown at trial
24 that the matter misrepresented:

25 (1) was material to the risk; or

26 (2) contributed to the contingency or event on which
27 the policy became due and payable.

28 (c) It is a question of fact whether a misrepresentation
29 made in the application for the policy or in the policy itself was
30 material to the risk or contributed to the contingency or event on
31 which the policy became due and payable. (V.T.I.C. Art. 21.16
32 (part).)

33 Source Law

34 Art. 21.16. Any provision in any . . . policy of
35 insurance . . . which provides that the answers or
36 statements made in the application for such contract
37 or in the contract of insurance, if untrue or false,

1 shall render the contract or policy void or voidable,
2 shall be of no effect, and shall not constitute any
3 defense to any suit brought upon such contract, unless
4 it be shown upon the trial thereof that the matter or
5 thing misrepresented was material to the risk or
6 actually contributed to the contingency or event on
7 which said policy became due and payable, and whether
8 it was material and so contributed in any case shall be
9 a question of fact to be determined by the court or
10 jury trying such case.

11 Revisor's Note

12 (1) V.T.I.C. Article 21.16 refers to "untrue or
13 false" answers or statements. The revised law omits
14 "untrue" as unnecessary because the meaning of
15 "untrue" is included in the meaning of "false."

16 (2) V.T.I.C. Article 21.16 refers to false
17 "answers or statements" made in the application for a
18 policy or in the policy. The revised law omits
19 "answers" as unnecessary because an answer is a type of
20 statement.

21 (3) V.T.I.C. Article 21.16 refers to a "matter
22 or thing misrepresented." The revised law omits "or
23 thing" as unnecessary because the meaning of "thing"
24 is included in the meaning of "matter."

25 (4) V.T.I.C. Article 21.16 states that a matter
26 must have "actually contributed" to a contingency or
27 event. The revised law omits "actually" as
28 unnecessary. "Contributed" means "actually
29 contributed."

30 (5) V.T.I.C. Article 21.16 refers to facts "to
31 be determined by the court or jury trying such case."
32 The revised law omits the quoted language as
33 unnecessary because even without the language, a court
34 or jury, as applicable, would determine a question of
35 fact in a case.

36 Revised Law

37 Sec. 705.005. NOTICE TO INSURED OF
38 MISREPRESENTATIONS. (a) This section applies to any suit brought
39 on an insurance policy issued or contracted for after June 29, 1903.

1 (b) A defendant may use as a defense a misrepresentation
2 made in the application for or in obtaining an insurance policy only
3 if the defendant shows at trial that before the 91st day after the
4 date the defendant discovered the falsity of the representation,
5 the defendant gave notice that the defendant refused to be bound by
6 the policy:

7 (1) to the insured, if living; or

8 (2) to the owners or beneficiaries of the insurance
9 policy, if the insured was deceased.

10 (c) This section does not:

11 (1) make available as a defense an immaterial
12 misrepresentation; or

13 (2) affect the provisions of Section 705.004.
14 (V.T.I.C. Art. 21.17 (part).)

15 Source Law

16 Art. 21.17. In all suits brought upon insurance
17 . . . policies hereafter issued or contracted for
18 . . ., no defense based upon misrepresentations made
19 in the applications for, or in obtaining or securing
20 the said contract, shall be valid, unless the
21 defendant shall show on the trial that, within a
22 reasonable time after discovering the falsity of the
23 representations so made, it gave notice to the
24 assured, if living, or, if dead, to the owners or
25 beneficiaries of said contract, that it refused to be
26 bound by the contract or policy; provided, that ninety
27 days shall be a reasonable time; provided, also, that
28 this article shall not be construed as to render
29 available as a defense any immaterial
30 misrepresentation, nor to in any wise modify or affect
31 Article 21.16 of this code.

32 Revisor's Note

33 (1) V.T.I.C. Article 21.17 refers to policies
34 "hereafter" issued or contracted for. The original
35 text of V.T.I.C. Article 21.17 was enacted by Chapter
36 LXIX, Acts of the 28th Legislature, Regular Session,
37 1903, which took effect on June 30, 1903. The revised
38 law therefore substitutes "after June 29, 1903" for
39 "hereafter."

40 (2) V.T.I.C. Article 21.17 refers to
41 misrepresentations made in "obtaining or securing" an

1 insurance policy. Throughout this chapter, the
2 revised law omits "or securing" because "obtaining"
3 and "securing" are synonymous in this context.

4 (3) V.T.I.C. Article 21.17 uses the term
5 "assured" to mean the person insured under an
6 insurance policy. Throughout this chapter, the
7 revised law substitutes "insured" because the terms
8 are synonymous and "insured" is more commonly used.

9 (4) V.T.I.C. Article 21.17 states that the
10 article may not be used "to in any wise modify or
11 affect Article 21.16." The revised law omits "modify"
12 because its meaning is included in the meaning of
13 "affect."

14 [Sections 705.006-705.050 reserved for expansion]

15 SUBCHAPTER B. SPECIAL PROVISIONS RELATED TO LIFE, ACCIDENT,
16 AND HEALTH INSURANCE POLICIES

17 Revised Law

18 Sec. 705.051. IMMATERIAL MISREPRESENTATION IN LIFE,
19 ACCIDENT, OR HEALTH INSURANCE APPLICATION. A misrepresentation in
20 an application for a life, accident, or health insurance policy
21 does not defeat recovery under the policy unless the
22 misrepresentation:

- 23 (1) is of a material fact; and
24 (2) affects the risks assumed. (V.T.I.C. Art. 21.18.)

25 Source Law

26 Art. 21.18. No recovery upon any life, accident
27 or health insurance policy shall ever be defeated
28 because of any misrepresentation in the application
29 which is of an immaterial fact and which does not
30 affect the risks assumed.

31 [Sections 705.052-705.100 reserved for expansion]

32 SUBCHAPTER C. SPECIAL PROVISIONS RELATED TO LIFE INSURANCE
33 POLICIES

34 Revised Law

35 Sec. 705.101. DEFINITION. In this subchapter, "insurance
36 policy" means a contract or policy of insurance. (V.T.I.C. Art.

1 21.35 (part).)

2 Source Law

3 Art. 21.35. . . . contract or policy of . . .
4 insurance

5 Revisor's Note

6 The definition of "insurance policy" is added to
7 the revised law for drafting convenience and to
8 eliminate frequent, unnecessary repetition of the
9 substance of the definition.

10 Revised Law

11 Sec. 705.102. APPLICABILITY OF SUBCHAPTER. This
12 subchapter applies to any insurance policy issued or contracted
13 for in this state. (V.T.I.C. Art. 21.35 (part).)

14 Source Law

15 Art. 21.35. . . . every . . . policy of . . .
16 insurance issued or contracted for in this State
17

18 Revised Law

19 Sec. 705.103. DOCUMENTS TO ACCOMPANY POLICY. Except as
20 otherwise provided by this code, a life insurance policy must be
21 accompanied by a copy of:

- 22 (1) the policy application; and
- 23 (2) any questions and answers given in connection with

24 the application. (V.T.I.C. Art. 21.35 (part).)

25 Source Law

26 Art. 21.35. Except as otherwise provided in this
27 code, every contract or policy of life insurance
28 issued or contracted for in this State shall be
29 accompanied by a written, photographic or printed copy
30 of the application for such insurance policy or
31 contract, as well as a copy of all questions asked and
32 answers given thereto. . . .

33 Revisor's Note

34 V.T.I.C. Article 21.35 refers to a "written,
35 photographic or printed copy of the application" for
36 the policy. The revised law omits "written,
37 photographic or printed" as unnecessary because the
38 meaning of those words is included in the meaning of

1 "copy."

2 Revised Law

3 Sec. 705.104. MISREPRESENTATION IN APPLICATION FOR LIFE
4 INSURANCE. A defense based on a misrepresentation in the
5 application for, or in obtaining, a life insurance policy on the
6 life of a person in or residing in this state is not valid or
7 enforceable in a suit brought on the policy on or after the second
8 anniversary of the date of issuance of the policy if premiums due on
9 the policy during the two years have been paid to and received by
10 the insurer, unless:

11 (1) the insurer has notified the insured of the
12 insurer's intention to rescind the policy because of the
13 misrepresentation; or

14 (2) it is shown at the trial that the
15 misrepresentation was:

16 (A) material to the risk; and

17 (B) intentionally made. (V.T.I.C. Art. 21.35
18 (part).)

19 Source Law

20 Art. 21.35. . . . provided further, that no
21 defense based upon misrepresentation made in the
22 application for, or in obtaining or securing, any
23 contract of insurance upon the life of any person being
24 or residing in this State shall be valid or enforceable
25 in any suit brought upon such contract two (2) years or
26 more after the date of its issuance, when premiums due
27 on such contract for the said term of two (2) years
28 have been paid to, and received by, the company issuing
29 such contract, without notice to the assured by the
30 company so issuing such contract of its intention to
31 rescind the same on account of misrepresentation so
32 made, unless it shall be shown on the trial that such
33 misrepresentation was material to the risk and
34 intentionally made.

35 Revised Law

36 Sec. 705.105. APPLICABILITY OF OTHER LAW. Subchapter A
37 does not apply to a life insurance policy:

38 (1) that contains a provision making the policy
39 incontestable after two years or less; and

40 (2) on which premiums have been duly paid. (V.T.I.C.
41 Art. 21.35 (part).)

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Source Law

Art. 21.35. . . . The provisions of Articles 21.16, 21.17, and 21.19 of this code shall not apply to policies of life insurance in which there is a clause making such policy indisputable after two (2) years or less, provided premiums are duly paid;

Revisor's Note

V.T.I.C. Article 21.35 refers to a clause making a policy "indisputable." The revised law substitutes "incontestable" for "indisputable" for consistency of terminology in this code and because "incontestable" is the more commonly used modern term.

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE A. HEALTH COVERAGE IN GENERAL

- CHAPTER 1201. ACCIDENT AND HEALTH INSURANCE
- CHAPTER 1202. CANCELLATION AND CONTINUATION OF POLICIES
IN GENERAL
- CHAPTER 1203. COORDINATION OF BENEFITS PROVISIONS
- CHAPTER 1204. PROCEDURES FOR PAYMENT OF CERTAIN HEALTH AND
ACCIDENT INSURANCE POLICY OR PLAN BENEFITS
- CHAPTER 1205. CERTIFICATION OF CREDITABLE COVERAGE
- CHAPTER 1206. DENIAL OF HEALTH BENEFIT PLAN ENROLLMENT
BASED ON EXISTING COVERAGE PROHIBITED
- CHAPTER 1207. ENROLLMENT OF MEDICAL ASSISTANCE RECIPIENTS
AND CHILDREN ELIGIBLE FOR STATE CHILD
HEALTH PLAN
- CHAPTER 1208. IDENTITY OF AVAILABLE EMPLOYEE OF HEALTH
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- CHAPTER 1209. HEALTH BENEFIT CLAIMS COST INFORMATION
- CHAPTER 1210. NOTICE OF CERTAIN POLICY PROVISIONS

[Chapters 1211-1250 reserved for expansion]

SUBTITLE B. GROUP HEALTH COVERAGE

- CHAPTER 1251. GROUP AND BLANKET HEALTH INSURANCE
- CHAPTER 1252. DISCONTINUATION AND REPLACEMENT OF GROUP
AND GROUP-TYPE HEALTH BENEFIT PLAN COVERAGE

1 CHAPTER 1253. CANCELLATION OF GROUP COVERAGE IN CERTAIN
2 CIRCUMSTANCES
3 CHAPTER 1254. NOTICE OF RATE INCREASE FOR GROUP HEALTH AND
4 ACCIDENT COVERAGE
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6 SUBTITLE C. MANAGED CARE
7 CHAPTER 1271. BENEFITS PROVIDED BY HEALTH MAINTENANCE
8 ORGANIZATIONS; EVIDENCE OF COVERAGE;
9 CHARGES
10 CHAPTER 1272. DELEGATION OF CERTAIN FUNCTIONS BY HEALTH
11 MAINTENANCE ORGANIZATION
12 CHAPTER 1273. POINT-OF-SERVICE PLANS
13 [Chapters 1274-1300 reserved for expansion]
14 SUBTITLE D. PREFERRED PROVIDER BENEFIT PLANS
15 CHAPTER 1301. PREFERRED PROVIDER BENEFIT PLANS
16 [Chapters 1302-1350 reserved for expansion]
17 SUBTITLE E. BENEFITS PAYABLE UNDER HEALTH COVERAGES
18 CHAPTER 1351. HOME HEALTH SERVICES
19 CHAPTER 1352. BRAIN INJURY
20 CHAPTER 1353. IMMUNIZATION OR VACCINATION PROTOCOLS UNDER
21 MANAGED CARE PLANS
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23 CHAPTER 1355. BENEFITS FOR CERTAIN MENTAL DISORDERS
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31 CHAPTER 1361. DETECTION AND PREVENTION OF OSTEOPOROSIS
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12 CHAPTER 1452. PHYSICIAN AND PROVIDER CREDENTIALS
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16 CHAPTER 1455. TELEMEDICINE AND TELEHEALTH
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20 AND AVAILABILITY ACT
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22 CHAPTER 1503. COVERAGE OF CERTAIN STUDENTS
23 CHAPTER 1504. MEDICAL CHILD SUPPORT
24 CHAPTER 1505. GROUP INSURANCE PLANS FOR PERSONS 65 YEARS
25 OF AGE OR OLDER
26 CHAPTER 1506. TEXAS HEALTH INSURANCE RISK POOL
27 [Chapters 1507-1550 reserved for expansion]
28 SUBTITLE I. SPECIALIZED COVERAGES
29 CHAPTER 1651. LONG-TERM CARE BENEFIT PLANS
30 CHAPTER 1652. MEDICARE SUPPLEMENT BENEFIT PLANS

1 TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

2 SUBTITLE A. HEALTH COVERAGE IN GENERAL

3 CHAPTER 1201. ACCIDENT AND HEALTH INSURANCE

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15 CHAPTER 1201. ACCIDENT AND HEALTH INSURANCE
16 SUBCHAPTER A. GENERAL PROVISIONS
17 Revised Law
18 Sec. 1201.001. DEFINITIONS. In this chapter:
19 (1) "Accident and health insurance policy" includes
20 any policy or contract that provides insurance against loss
21 resulting from:
22 (A) accidental bodily injury;
23 (B) accidental death; or
24 (C) sickness.
25 (2) "Policy" means the entire contract between an
26 insurer and an insured and includes riders, endorsements, and the
27 application, if attached. (V.T.I.C. Art. 3.70-1, Secs. (B)(3),
28 (4).)
29 Source Law
30 (B) Definitions. As used in this Act,
31 (3) "Policy of accident and sickness
32 insurance" as used herein, includes any policy or
33 contract providing insurance against loss resulting
34 from sickness or from bodily injury or death by
35 accident or both.
36 (4) "Policy" means the entire contract
37 between the insurer and the insured, including the

1 policy, riders, endorsements, and the application, if
2 attached.

3 Revisor's Note

4 (1) Sections (B)(1) and (2), V.T.I.C. Article
5 3.70-1, define "board" and "commissioner." The
6 revised law omits those definitions as unnecessary.
7 Chapter 685, Acts of the 73rd Legislature, Regular
8 Session, 1993, abolished the State Board of Insurance
9 and transferred its functions to the commissioner of
10 insurance and the Texas Department of Insurance.
11 Throughout this chapter, references to the board have
12 been changed appropriately. In addition, Section
13 31.001 of this code defines "commissioner" for
14 purposes of this code and the other insurance laws of
15 this state to mean the commissioner of insurance. The
16 omitted law reads:

17 (1) "Board" shall mean the
18 State Board of Insurance of the State of
19 Texas.

20 (2) "Commissioner" shall mean
21 the Commissioner of Insurance of the State
22 of Texas.

23 (2) Section (B)(3), V.T.I.C. Article 3.70-1,
24 defines "policy of accident and sickness insurance."
25 Throughout this chapter, the revised law substitutes
26 "health" for "sickness" in this context for
27 consistency with modern usage.

28 Revised Law

29 Sec. 1201.002. PURPOSE. The purpose of this chapter is to:

30 (1) provide for reasonable standardization,
31 readability, and simplification of terms and coverages in
32 individual accident and health insurance policies;

33 (2) promote public understanding of coverages;

34 (3) eliminate provisions in individual accident and
35 health insurance policies that may be unjust, unfair, misleading,
36 or unreasonably confusing in connection with:

37 (A) the purchase of coverage; or

1 (B) the settlement of claims; and
2 (4) provide for full and fair disclosure in sales of
3 accident and health coverage. (V.T.I.C. Art. 3.70-1, Sec. (A).)

4 Source Law

5 Art. 3.70-1. (A) Purpose. The purpose of this
6 Act shall be to provide for reasonable
7 standardization, readability, and simplification of
8 terms and coverages contained in individual accident
9 and sickness insurance policies; to facilitate public
10 understanding of coverages; to eliminate provisions
11 contained in individual accident and sickness
12 insurance policies which may be unjust, unfair,
13 misleading, or unreasonably confusing in connection
14 either with the purchase of such coverages or with the
15 settlement of claims; and to provide for full and fair
16 disclosure in the sale of accident and sickness
17 coverages.

18 Revised Law

19 Sec. 1201.003. APPLICABILITY OF CHAPTER. (a) This chapter
20 applies only to an accident and health insurance policy delivered
21 or issued for delivery in this state.

22 (b) Except as otherwise provided by this chapter, this
23 chapter applies only to an individual accident and health insurance
24 policy delivered or issued for delivery by:

- 25 (1) a life, health, and accident insurance company;
- 26 (2) a mutual insurance company, including:
 - 27 (A) a mutual life insurance company; and
 - 28 (B) a mutual assessment life insurance company;
- 29 (3) a local mutual aid association;
- 30 (4) a mutual or natural premium life or casualty
31 insurance company;
- 32 (5) a general casualty company;
- 33 (6) a Lloyd's plan;
- 34 (7) a reciprocal or interinsurance exchange;
- 35 (8) a nonprofit hospital, medical, or dental service
36 corporation, including a corporation operating under Chapter 842;
37 or
- 38 (9) another insurer required by law to be authorized
39 by the department.

40 (c) This chapter applies to an accident and health insurance

1 policy issued by a stipulated premium company subject to Chapter
2 884.

3 (d) This chapter does not apply to:

4 (1) any society, company, or other insurer whose
5 activities are exempt by statute from the control of the department
6 and that is entitled by statute to a certificate from the department
7 that shows the entity's exempt status;

8 (2) a credit accident and health insurance policy
9 issued under Chapter 1153;

10 (3) a workers' compensation insurance policy;

11 (4) a liability insurance policy, with or without
12 supplementary expense coverage;

13 (5) a reinsurance policy or contract;

14 (6) a blanket or group insurance policy, except as
15 otherwise provided by this chapter; or

16 (7) a life insurance endowment or annuity contract or
17 a contract supplemental to a life insurance endowment or annuity
18 contract if the contract or supplemental contract contains only
19 provisions relating to accident and health insurance that:

20 (A) provide additional benefits in case of
21 accidental death, accidental dismemberment, or accidental loss of
22 sight; or

23 (B) operate to:

24 (i) safeguard the contract or supplemental
25 contract against lapse; or

26 (ii) give a special surrender value, a
27 special benefit, or an annuity if the insured or annuitant becomes
28 totally and permanently disabled, as defined by the contract or
29 supplemental contract.

30 (e) Subchapters C and D do not apply to a conversion policy
31 issued under a contractual conversion privilege under a group
32 accident and health insurance policy. (V.T.I.C. Art. 3.70-1, Sec.
33 (C) (part); Art. 3.70-8, Secs. (a) (part), (b).)

1 Source Law

2 [Art. 3.70-1]

3 (C) Scope of Act. This Act shall apply to and
4 govern individual accident and sickness insurance
5 policies delivered, or issued for delivery, in the
6 State of Texas by life, health and accident companies,
7 mutual life insurance companies, mutual assessment
8 life insurance companies, mutual insurance companies,
9 local mutual aid associations, mutual or natural
10 premium life or casualty insurance companies, general
11 casualty companies, Lloyds, reciprocal or
12 inter-insurance exchanges, nonprofit hospital,
13 medical, or dental service corporations including but
14 not limited to companies subject to Chapter 20 of this
15 code, as amended, stipulated premium insurance
16 companies, or any other insurer which by law is
17 required to be licensed by the Board; provided,
18 however, this Act shall not apply to any society,
19 company or other insurer whose activities are by
20 statute exempt from the control of the Board and which
21 are entitled by statute to an exemption certificate
22 from the Board in evidence of their exempt status; nor
23 to credit accident and sickness insurance policies
24 written under Article 3.53 of this code, as amended;
25 Conversion policies issued pursuant to a
26 contractual conversion privilege under a group
27 accident and sickness insurance policy shall not be
28 subject to Subsections (D) through (H) of this
29 article.

30 Art. 3.70-8. (a) Nothing in this Act shall apply
31 to or affect (1) any policy of workmen's compensation
32 insurance or any policy of liability insurance with or
33 without supplementary expense coverage therein; or (2)
34 any policy or contract of reinsurance; or (3) any
35 blanket or group policy of insurance except as
36 provided in Subsections . . . (C) of Section 2 and
37 Subdivision (5) of Subsection (F) of Section 1
38 and . . . ; or (4) life insurance endowment or annuity
39 contracts or contracts supplemental thereto which
40 contain only such provisions relating to accident and
41 sickness insurance as (a) provide additional benefits
42 in case of death or dismemberment or loss of sight by
43 accident, or as (b) operate to safeguard such
44 contracts against lapse, or to give a special
45 surrender value, special benefit, or an annuity in the
46 event that the insured or annuitant shall become
47 totally and permanently disabled, as defined by the
48 contract or supplemental contract, or (5) any policy
49 written under the provisions of Senate Bill No. 208,
50 Acts of the 51st Legislature, 1949.

51 (b) This Act applies to a health, accident,
52 sickness, and hospitalization policy issued by a
53 stipulated premium insurer subject to Chapter 884 of
54 this code.

55 Revisor's Note

56 (1) The provisions of law revised in this
57 chapter apply only to an accident and health insurance
58 policy delivered or issued for delivery in this state.
59 The revised law states this limitation as a limitation
60 on the applicability of the chapter for drafting

1 convenience and to avoid frequent repetition of the
2 substance of the language in subsequent sections of
3 this chapter. Accordingly, the revised law omits
4 references to "delivered or issued for delivery in
5 this state" in subsequent sections of this chapter.

6 (2) Section (C), V.T.I.C. Article 3.70-1,
7 provides that the act "shall apply to and govern"
8 certain policies. The revised law omits "govern"
9 because, in this context, "govern" is included in the
10 meaning of "apply to."

11 (3) Section (C), V.T.I.C. Article 3.70-1,
12 refers to companies, "including but not limited to"
13 certain companies. The revised law omits "but not
14 limited to" and similar language throughout this
15 chapter as unnecessary because Section 311.005(13),
16 Government Code (Code Construction Act), and Section
17 312.011(19), Government Code, provide that "includes"
18 and "including" are terms of enlargement and not of
19 limitation and do not create a presumption that
20 components not expressed are excluded. Those
21 definitions apply to the revised law.

22 (4) Section (C), V.T.I.C. Article 3.70-1,
23 refers to "Chapter 20 of this code, as amended" and
24 "Article 3.53 of this code, as amended." Throughout
25 this chapter, the revised law omits the references to
26 "as amended" in this and similar instances because,
27 under Section 311.027, Government Code (Code
28 Construction Act), applicable to the revised law,
29 unless expressly provided otherwise, a reference to a
30 statute applies to all reenactments, revisions, or
31 amendments of the statute.

32 (5) Section (C), V.T.I.C. Article 3.70-1,
33 refers to an insurer required by law to be "licensed"
34 by the board, meaning the Texas Department of

1 Insurance. The revised law substitutes "authorized"
2 for "licensed" because, under this code, an insurer
3 receives from the department a certificate of
4 authority, instead of a license, to act as an insurer.

5 (6) Section (C), V.T.I.C. Article 3.70-1,
6 provides that "Subsections (D) through (H) of this
7 article" do not apply to "[c]onversion policies issued
8 pursuant to a contractual conversion privilege under a
9 group accident and sickness insurance policy." The
10 revised law omits the reference to "Subsection (D)"
11 (revised as Section 1201.006), governing rulemaking
12 authority of the commissioner, because conversion
13 policies are subject to other provisions in this
14 chapter and commissioner rules adopted under
15 Subsection (D) implementing those provisions.

16 (7) Section (a), V.T.I.C. Article 3.70-8,
17 provides that "[n]othing in this Act shall apply to or
18 affect" certain matters. The revised law omits
19 "affect" because, in this context, "affect" is
20 included in the meaning of "apply to."

21 (8) Section (a), V.T.I.C. Article 3.70-8,
22 provides that the act does not apply to a blanket or
23 group insurance policy "except as provided in
24 Subsections . . . (C) of Section 2 and Subdivision (5)
25 of Subsection (F) of Section 1." The revised law
26 substitutes "except as otherwise provided by this
27 chapter" for the quoted language for clarity and
28 accuracy. The quoted language is misleading because
29 it does not provide a complete list of all provisions
30 in this chapter that apply to a blanket or group
31 policy. For example, Sections (L) and (M), V.T.I.C.
32 Article 3.70-2, revised in relevant part as Sections
33 1201.062 and 1201.063-1201.065, respectively, apply
34 explicitly to group policies, but a reference to those

1 provisions is not included in Article 3.70-8.

2 (9) Section (a), V.T.I.C. Article 3.70-8,
3 provides an exemption from the act for "any policy
4 written under the provisions of Senate Bill No. 208,
5 Acts of the 51st Legislature, 1949." The revised law
6 omits that exemption as unnecessary because it
7 duplicates the exemption provided by Section (C),
8 V.T.I.C. Article 3.70-1, to "credit accident and
9 sickness insurance policies written under Article
10 3.53," revised as Section 1201.003(d)(2).

11 (10) Section (b), V.T.I.C. Article 3.70-8,
12 refers to a "health, accident, sickness, and
13 hospitalization policy" issued by a stipulated premium
14 insurer. The revised law substitutes "accident and
15 health insurance policy" for the quoted language
16 because the terms are substantively identical and
17 "accident and health insurance policy" is the defined
18 term used throughout this chapter.

19 Revised Law

20 Sec. 1201.004. CONSTRUCTION OF CHAPTER. This chapter does
21 not enlarge the powers of an entity listed in Section 1201.003.
22 (V.T.I.C. Art. 3.70-1, Sec. (C) (part).)

23 Source Law

24 (C) . . . provided further, that this Act
25 shall not be construed to enlarge the powers of any of
26 the enumerated companies. . . .

27 Revised Law

28 Sec. 1201.005. REFERENCES TO CHAPTER. In this chapter, a
29 reference to this chapter includes a reference to:

30 (1) Section 1202.052;

31 (2) Section 1271.005(a), to the extent that the
32 subsection relates to the applicability of Section 1201.105, and
33 Sections 1271.005(d) and (e);

34 (3) Chapter 1351;

35 (4) Subchapters C and E, Chapter 1355;

- 1 (5) Chapter 1356;
2 (6) Chapter 1365;
3 (7) Subchapter A, Chapter 1367; and
4 (8) Subchapters A, B, and G, Chapter 1451. (New.)

5 Revisor's Note

6 This chapter is derived from a majority of the
7 articles previously contained in Subchapter G, Chapter
8 3, Insurance Code. Many of those articles were enacted
9 by Chapter 397, Acts of the 54th Legislature, Regular
10 Session, 1955, and references in those articles to
11 "this Act" are revised in this chapter as references to
12 "this chapter." However, the logical organization of
13 this code required various portions of Chapter 397
14 ("this Act") to be revised in other chapters of this
15 code. As a result, this new section is necessary to
16 ensure the continued applicability of provisions
17 revised in this chapter to the portions of Chapter 397
18 revised in other chapters.

19 Revised Law

20 Sec. 1201.006. RULEMAKING AUTHORITY. The commissioner may
21 adopt reasonable rules as necessary to implement the purposes and
22 provisions of this chapter. (V.T.I.C. Art. 3.70-1, Sec. (D).)

23 Source Law

24 (D) Rules and Regulations. The Board is
25 authorized to issue such reasonable rules and
26 regulations as may be necessary to carry out the
27 various purposes and provisions of this article.

28 Revisor's Note

29 (1) Section (D), V.T.I.C. Article 3.70-1,
30 refers to "rules and regulations." Throughout this
31 chapter, the revised law omits the reference to
32 "regulations" in this context because, under Section
33 311.005(5), Government Code (Code Construction Act), a
34 rule is defined to include a regulation. That
35 definition applies to the revised law.

1 Revisor's Note

2 The revised law omits certain provisions of
3 V.T.I.C. Article 3.70-10 relating to judicial review
4 because the provisions duplicate provisions contained
5 in Subchapter D, Chapter 36. The omitted law reads:

6 Art. 3.70-10. . . . [If any insurer
7 be dissatisfied with any decision,
8 regulation, order, rule, act, or
9 administrative ruling adopted by the Board
10 or the commissioner under the provisions of
11 this Act, such dissatisfied insurer may
12 file a petition] setting forth the
13 particular objection to such decision,
14 regulation, order, rule, act or
15 administrative ruling, or to either or all
16 of them, in a District Court of Travis
17 County, Texas, and not elsewhere, against
18 the Board or the commissioner as
19 defendant. . . . Either party to the
20 action may appeal to the Appellate Court
21 having jurisdiction of the cause and the
22 appeal shall be at once returnable to the
23 Appellate Court having jurisdiction of the
24 cause and the action so appealed shall have
25 precedence in the Appellate Court over all
26 causes of a different character therein
27 pending. The Board or the commissioner
28 shall not be required to give any appeal
29 bond in any cause arising hereunder.

30 Revised Law

31 Sec. 1201.009. NONCONFORMING POLICY. (a) This chapter
32 governs the rights, duties, and obligations of the insurer, the
33 insured, and the beneficiary of an accident and health insurance
34 policy regardless of a provision in the policy that conflicts with
35 this chapter.

36 (b) An accident and health insurance policy that violates
37 this chapter is a valid policy, but the policy shall be construed in
38 a manner to make the policy consistent with this chapter. (V.T.I.C.
39 Art. 3.70-4, Sec. (B).)

40 Source Law

41 (B) Policy Conflicting with this Act. A policy
42 delivered or issued for delivery to any person in this
43 state in violation of this Act shall be held valid but
44 shall be construed as provided in this Act. When any
45 provision in a policy subject to this Act is in
46 conflict with any provision of this Act, the rights,
47 duties and obligations of the insurer, the insured and
48 the beneficiary shall be governed by the provisions of
49 this Act.

1 Revised Law

2 Sec. 1201.010. THIRD-PARTY OWNERSHIP OF POLICY. The use of
3 "insured" in this chapter does not prevent a person with an
4 insurable interest, other than the insured, from:

5 (1) applying for and owning an individual accident and
6 health insurance policy covering the insured; or

7 (2) being entitled to an indemnity, right, or benefit
8 provided for in an individual accident and health insurance policy
9 covering the insured. (V.T.I.C. Art. 3.70-3, Sec. (E).)

10 Source Law

11 (E) Third Party Ownership. The word "insured"
12 as used in this Act, shall not be construed as
13 preventing a person other than the insured with a
14 proper insurable interest from making application for
15 and owning a policy covering the insured or from being
16 entitled under such a policy to any indemnities,
17 benefits and rights provided therein.

18 Revisor's Note

19 Section (E), V.T.I.C. Article 3.70-3, refers to a
20 "policy." The majority of Subchapter G, V.T.I.C.
21 Chapter 3, including Article 3.70-3, was enacted as
22 Chapter 397, Acts of the 54th Legislature, Regular
23 Session, 1955, and is revised as this chapter. These
24 provisions, as originally enacted, governed
25 individual accident and sickness insurance policies.
26 See, for example, Section (A), V.T.I.C. Article
27 3.70-1, revised as Section 1201.002, and Section (C),
28 V.T.I.C. Article 3.70-1, and Section (a), V.T.I.C.
29 Article 3.70-8, revised in relevant part as Section
30 1201.003. Subsequent amendments to Chapter 397 added
31 provisions that also apply to group and franchise
32 accident and health insurance policies. Throughout
33 this chapter, the revised law adds a reference to an
34 "individual" policy where appropriate to clarify the
35 application of the law.

36 Revised Law

37 Sec. 1201.011. COVERAGE FOR PREMIUM PERIOD WITH LIMITATIONS

1 BY AGE OR DATE; MISSTATEMENT OF AGE OF INSURED. (a) Regardless of
2 a provision in an individual accident and health insurance policy
3 that specifies a date, by age limitation or otherwise, after which
4 coverage under the policy is not effective, coverage continues in
5 force, subject to any right of cancellation, until the end of the
6 period for which the insurer accepts a premium if:

7 (1) the insurer accepts the premium after the
8 specified date; or

9 (2) the specified date falls before the end of the
10 period for which the insurer accepts the premium.

11 (b) Notwithstanding Subsection (a), if the age of the
12 insured is misstated and, because of the insured's correct age,
13 coverage of the insured would not have become effective or would
14 have terminated before the insurer's acceptance of a premium, the
15 liability of the insurer is limited to the refund, on request, of
16 the premiums paid for the period not covered by the policy.
17 (V.T.I.C. Art. 3.70-7.)

18 Source Law

19 Art. 3.70-7. If any such policy contains a
20 provision establishing, as an age limit or otherwise,
21 a date after which the coverage provided by the policy
22 will not be effective, and if such date falls within a
23 period for which premium is accepted by the insurer or
24 if the insurer accepts a premium after such date the
25 coverage provided by the policy will continue in force
26 subject to any right of cancellation until the end of
27 the period for which premium has been accepted. In the
28 event the age of the insured has been misstated and if,
29 according to the correct age of the insured, the
30 coverage provided by the policy would not have become
31 effective, or would have ceased prior to the
32 acceptance of such premium or premiums, then the
33 liability of the insurer shall be limited to the
34 refund, upon request, of all premiums paid for the
35 period not covered by the policy.

36 Revised Law

37 Sec. 1201.012. DEFENSE OF CLAIM. The following actions by
38 an insurer do not operate as a waiver of the insurer's rights in
39 defense of a claim that arises under an individual accident and
40 health insurance policy:

41 (1) acknowledgment of the receipt of notice given
42 under the policy;

- 1 (2) provision of a form for filing a proof of loss;
2 (3) acceptance of a proof of loss; or
3 (4) investigation of a claim under the policy.
4 (V.T.I.C. Art. 3.70-6.)

5 Source Law

6 Art. 3.70-6. The acknowledgment by any insurer
7 of the receipt of notice given under any policy covered
8 by this Act, or the furnishing of forms for filing
9 proofs of loss, or the acceptance of such proofs, or
10 the investigation of any claim thereunder shall not
11 operate as a waiver of any of the rights of the insurer
12 in defense of any claim arising under such policy.

13 Revisor's Note
14 (End of Subchapter)

15 Section (I), V.T.I.C. Article 3.70-1, provides
16 that rules adopted under Article 3.70-1 are subject to
17 the notice and hearing requirements of V.T.I.C.
18 Article 3.70-10, revised in relevant part as Section
19 1201.007. The revised law omits the section as
20 unnecessary because Article 3.70-10 applies on its own
21 terms to rules adopted under Article 3.70-1. The
22 omitted law reads:

23 (I) Administrative Procedures. Rules
24 and regulations promulgated pursuant to
25 this Article shall be subject to notice and
26 hearing pursuant to Section 10, Chapter
27 397, Acts of the 54th Legislature, Regular
28 Session, 1955 (Article 3.70-10, Vernon's
29 Texas Insurance Code).

30 [Sections 1201.013-1201.050 reserved for expansion]

31 SUBCHAPTER B. POLICY TERMS

32 Revised Law

33 Sec. 1201.051. ENTIRE CONSIDERATION. An individual
34 accident and health insurance policy must state the entire monetary
35 and other consideration for the policy in the policy or in the
36 application, if the application is made a part of the policy.
37 (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

38 Source Law

39 Art. 3.70-2. (A) No policy of accident and
40 sickness insurance shall be delivered or issued for
41 delivery to any person in this state unless:
42 (1) the entire money and other

1 consideration therefor are expressed therein or in the
2 application, if it is made a part of the policy; and

3 . . .

4 Revised Law

5 Sec. 1201.052. TIME OF EFFECTIVENESS AND TERMINATION. An
6 individual accident and health insurance policy must state the time
7 the insurance takes effect and the time the insurance terminates.
8 (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

9 Source Law

10 (A) No policy of accident and sickness insurance
11 shall be delivered or issued for delivery to any person
12 in this state unless:

13 . . .
14 (2) the time at which the insurance takes
15 effect and terminates is expressed therein; and

16 . . .

17 Revised Law

18 Sec. 1201.053. PERSONS INSURED. (a) Except as provided
19 by this section, an individual accident and health insurance policy
20 may not insure more than one individual.

21 (b) On the application of an adult member of a family, an
22 individual accident and health insurance policy may, at the time of
23 original issuance or by subsequent amendment, insure two or more
24 eligible members of the adult's family, including a spouse,
25 unmarried children younger than 25 years of age, including a
26 grandchild of the adult as described by Section 1201.062(a)(1), a
27 child the adult is required to insure under a medical support order
28 issued under Chapter 154, Family Code, or enforceable by a court in
29 this state, and any other individual dependent on the adult.

30 (c) The adult who applies for the individual accident and
31 health insurance policy is considered the policyholder. (V.T.I.C.
32 Art. 3.70-2, Sec. (A) (part), as amended Acts 77th Leg., R.S., Chs.
33 396 and 1027.)

34 Source Law

35 (A) [as amended Acts 77th Leg., R.S., Ch. 396]
36 No policy of accident and sickness insurance shall be
37 delivered or issued for delivery to any person in this
38 state unless:

39 . . .
40 (3) it purports to insure only one person,
41 except that a policy may insure, originally or by
42 subsequent amendment, upon the application of an adult

1 member of a family who shall be deemed the policy
2 holder, any two or more eligible members of that
3 family, including:

4 (a) the spouse of the policy holder;
5 (b) a dependent child of the policy
6 holder or any child under a specified age that may not
7 exceed 25 years of age;

8 (c) a dependent grandchild of the
9 policy holder who is less than 21 years old and living
10 with and in the household of the policy holder;
11 provided that, for purposes of this paragraph, a
12 grandchild of a policy holder is a dependent of the
13 policy holder regardless of whether the policy holder
14 treats the grandchild as a dependent for federal
15 income tax purposes;

16 (d) a child the policy holder is
17 required to insure under a medical support order
18 issued under Chapter 154, Family Code, or enforceable
19 by a court in this state; and

20 (e) any other person dependent upon
21 the policy holder; and
22 . . .

23 (A) [as amended Acts 77th Leg., R.S., Ch. 1027]
24 No policy of accident and sickness insurance shall be
25 delivered or issued for delivery to any person in this
26 state unless:

27 . . .
28 (3) it purports to insure only one person,
29 except that a policy may insure, originally or by
30 subsequent amendment, upon the application of an adult
31 member of a family who shall be deemed the policy
32 holder, any two or more eligible members of that
33 family, including husband, wife, unmarried children
34 under 25 years of age, including a grandchild of the
35 policy holder as described by Section (L) of this
36 article, a child the policy holder is required to
37 insure under a medical support order issued under
38 Chapter 154, Family Code, or enforceable by a court in
39 this state, and any other person dependent upon the
40 policy holder; and
41 . . .

42 Revisor's Note

43 Section (A)(3), V.T.I.C. Article 3.70-2, was
44 amended twice during the 77th Legislative Session.
45 Chapter 1027, Acts of the 77th Legislature, Regular
46 Session, 2001, amended Section (A)(3) to permit an
47 individual accident and health insurance policy to
48 insure an unmarried child who is younger than 25 years
49 of age and a "grandchild of the policy holder as
50 described by Section (L)." Section (L), V.T.I.C.
51 Article 3.70-2, as amended by Chapter 1027 and revised
52 in relevant part as Section 1201.062(a)(1), provides
53 for coverage of an unmarried grandchild who is younger
54 than 25 years of age and is a dependent of the adult for

1 federal income tax purposes at the time application
2 for coverage of the grandchild is made.

3 Chapter 396, Acts of the 77th Legislature,
4 Regular Session, 2001, amended Section (A)(3) to
5 permit an individual accident and health insurance
6 policy to insure a dependent child, any child under a
7 specified age that may not exceed 25 years of age, and
8 a dependent grandchild who is younger than 21 years of
9 age and who lives in the adult's household. In
10 addition, Chapter 396 amended Section (A)(3) to
11 provide that a grandchild of the adult is a dependent
12 regardless of whether the adult treats the grandchild
13 as a dependent for federal income tax purposes.

14 It is impossible to give effect to both
15 amendments made by Chapters 396 and 1027 regarding
16 coverage for dependent children and other children and
17 regarding the issue of whether a grandchild is
18 required to be a dependent for federal income tax
19 purposes. Under basic rules of statutory
20 construction, codified in Sections 311.025 and
21 312.014, Government Code, if it is impossible to read
22 two acts of the same legislative session together so
23 that effect may be given to both, the latest enactment
24 is read as an implied repeal of the earlier act to the
25 extent of the conflict. The last legislative action on
26 Chapter 396 occurred on May 15, 2001. The last
27 legislative action on Chapter 1027 occurred on May 22,
28 2001. Under Sections 311.025 and 312.014, Government
29 Code, the amendment to Section (A)(3), Article 3.70-2,
30 made by Chapter 1027 impliedly repealed the amendment
31 adopted under Chapter 396. The revised law
32 accordingly is drafted to reflect the amendment to
33 Section (A)(3) made by Chapter 1027 and to omit the
34 amendment to Section (A)(3) made by Chapter 396.

1 Revised Law

2 Sec. 1201.054. APPEARANCE OF TEXT. (a) In this section,
3 "text" includes all printed matter of an individual accident and
4 health insurance policy except:

- 5 (1) the name and address of the insurer;
6 (2) the name or title of the policy;
7 (3) the brief description, if any; and
8 (4) captions and subcaptions.

9 (b) An individual accident and health insurance policy must
10 have:

11 (1) a style, arrangement, or overall appearance that
12 does not give undue prominence to any portion of the text; and

13 (2) every printed portion of its text and of any
14 endorsements or attached papers printed plainly in a lightfaced
15 type:

16 (A) of a style in general use; and

17 (B) in a uniform size not less than 10-point with
18 a lowercase unspaced alphabet length not less than 120-point.

19 (c) Subsection (b)(2) does not apply to a copy of an
20 application or identification card. (V.T.I.C. Art. 3.70-2, Sec.
21 (A) (part).)

22 Source Law

23 (A) No policy of accident and sickness insurance
24 shall be delivered or issued for delivery to any person
25 in this state unless:

26 . . .
27 (4) the style, arrangement and over-all
28 appearance of the policy gives no undue prominence to
29 any portion of the text, and unless every printed
30 portion of the text of the policy and of any
31 endorsements or attached papers (except copies of
32 applications and identification cards) are plainly
33 printed in lightfaced type of a style in general use,
34 the size of which shall be uniform and not less than
35 ten-point with a lower-case unspaced alphabet length
36 not less than one hundred and twenty-point (the "text"
37 shall include all printed matter except the name and
38 address of the insurer, name or title of the policy,
39 the brief description, if any, and captions and
40 subcaptions); and
41 . . .

42 Revised Law

43 Sec. 1201.055. EXCEPTIONS AND REDUCTIONS OF INDEMNITY. (a)

1 An individual accident and health insurance policy must state each
2 exception to or reduction of indemnity for the policy.

3 (b) Except as provided by Subchapter E, each exception to or
4 reduction of indemnity for the policy must be printed, at the
5 insurer's option:

6 (1) with the benefit provision to which the exception
7 or reduction applies; or

8 (2) under an appropriate caption such as:

9 (A) "Exceptions"; or

10 (B) "Exceptions and Reductions."

11 (c) Notwithstanding Subsection (b), if an exception or
12 reduction specifically applies only to a particular benefit of an
13 individual accident and health insurance policy, the statement of
14 the exception or reduction must be included with the benefit
15 provision to which the exception or reduction applies. (V.T.I.C.
16 Art. 3.70-2, Sec. (A) (part).)

17 Source Law

18 (A) No policy of accident and sickness insurance
19 shall be delivered or issued for delivery to any person
20 in this state unless:

21 . . .
22 (5) the exceptions and reductions of
23 indemnity are set forth in the policy and, except those
24 which are set forth in Section 3 of this Act, are
25 printed, at the insurer's option, either included with
26 the benefit provision to which they apply, or under an
27 appropriate caption such as "Exceptions" or
28 "Exceptions and Reductions"; provided that if an
29 exception or reduction specifically applies only to a
30 particular benefit of the policy, a statement of such
31 exception or reduction shall be included with the
32 benefit provision to which it applies; and
33 . . .

34 Revised Law

35 Sec. 1201.056. FORM NUMBER. Each form that constitutes a
36 part of an individual accident and health insurance policy,
37 including each rider or endorsement, must be identified by a form
38 number placed in the lower left corner of the first page of the
39 form. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

40 Source Law

41 (A) No policy of accident and sickness insurance
42 shall be delivered or issued for delivery to any person

1 in this state unless:

2 . . .
3 (6) each such form, including riders and
4 endorsements, shall be identified by a form number in
5 the lower left-hand corner of the first page thereof;
6 and
7 . . .

8 Revised Law

9 Sec. 1201.057. INCORPORATION OF OR REFERENCE TO OTHER
10 DOCUMENTS. (a) An individual accident and health insurance
11 policy that provides that a portion of the charter, rules,
12 constitution, or bylaws of the insurer are a part of the policy must
13 state that portion fully in the policy.

14 (b) An individual accident and health insurance policy may
15 incorporate or refer to:

- 16 (1) a statement of rates or classification of risks;
17 or
18 (2) a short-rate table filed with the department.

19 (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

20 Source Law

21 (A) No policy of accident and sickness insurance
22 shall be delivered or issued for delivery to any person
23 in this state unless:

24 . . .
25 (7) it contains no provision purporting to
26 make any portion of the charter, rules, constitution,
27 or bylaws of the insurer a part of the policy unless
28 such portion is set forth in full in the policy, except
29 in the case of the incorporation of, or reference to, a
30 statement of rates or classification of risks, or
31 shortrate table filed with the Board; and
32 . . .

33 Revised Law

34 Sec. 1201.058. NOTIFICATION THAT POLICY IS RETURNABLE;
35 EFFECT OF RETURN. (a) An individual accident and health
36 insurance policy must include a notice that states in substance
37 that the individual to whom the policy is issued is entitled to have
38 the premium paid refunded if, after the individual examines the
39 policy, the individual is not satisfied with the policy for any
40 reason and returns the policy not later than the 10th day after the
41 date the policy is delivered to the individual.

42 (b) An individual accident and health insurance policy
43 returned to the insurer at the insurer's home or branch office or to

1 the agent through whom the policy was purchased within the time
2 provided by the notice is void from the date the policy was issued,
3 and the parties are in the same position as if the policy had not
4 been issued.

5 (c) The notice required by this section may be printed on
6 the policy or attached to the policy.

7 (d) This section does not apply to a single premium
8 nonrenewable policy. (V.T.I.C. Art. 3.70-2, Sec. (A) (part).)

9 Source Law

10 (A) No policy of accident and sickness insurance
11 shall be delivered or issued for delivery to any person
12 in this state unless:

13
14 (8) it shall have printed thereon or
15 attached thereto a notice stating in substance that
16 the person to whom the policy is issued shall be
17 permitted to return the policy within ten (10) days of
18 its delivery to such person and to have the premium
19 paid refunded if, after examination of the policy,
20 such person is not satisfied with it for any reason.
21 If such person pursuant to such notice, returns the
22 policy to the insurer at its home or branch office or
23 to the agent through whom it was purchased, it shall be
24 void from the beginning and the parties shall be in the
25 same position as if no policy had been issued. This
26 subdivision shall not apply to single premium
27 nonrenewable policies.

28 Revised Law

29 Sec. 1201.059. TERMINATION OF COVERAGE BASED ON AGE OF
30 CHILD IN INDIVIDUAL, BLANKET, OR GROUP POLICY. (a) An accident and
31 health insurance policy, including an individual, blanket, or group
32 policy, and including a policy issued by a corporation operating
33 under Chapter 842, that provides that coverage of a child
34 terminates when the child attains a limiting age specified in the
35 policy must provide in substance that the child's attainment of
36 that age does not terminate coverage while the child is:

37 (1) incapable of self-sustaining employment because
38 of mental retardation or physical disability; and

39 (2) chiefly dependent on the insured or group member
40 for support and maintenance.

41 (b) To obtain coverage for a child as described by
42 Subsection (a), the insured or group member must provide to the

1 insurer proof of the child's incapacity and dependency:

2 (1) not later than the 31st day after the date the
3 child attains the limiting age; and

4 (2) subsequently as the insurer requires, except that
5 the insurer may not require proof more frequently than annually
6 after the second anniversary of the date the child attains the
7 limiting age. (V.T.I.C. Art. 3.70-2, Sec. (C); Art. 3.70-8, Sec.
8 (a) (part).)

9 Source Law

10 [Art. 3.70-2]

11 (C) Any policy of accident and sickness
12 insurance, including policies issued by companies
13 subject to Chapter 20, Texas Insurance Code, as
14 amended, delivered or issued for delivery in this
15 state, which provides that coverage of a child shall
16 terminate upon attainment of the limiting age for
17 children specified in the policy shall also provide in
18 substance that attainment of the limiting age shall
19 not operate to terminate the coverage of the child
20 while the child is both (1) incapable of
21 self-sustaining employment by reason of mental
22 retardation or physical handicap and (2) chiefly
23 dependent upon the insured for support and
24 maintenance. Proof of the incapacity and dependency
25 shall be furnished to the insurer by the insured within
26 31 days of the child's attainment of the limiting age
27 and subsequently as may be required by the insurer but
28 not more frequently than annually after the two-year
29 period following the child's attainment of the
30 limiting age.

31 Art. 3.70-8. (a) [Nothing in this Act shall
32 apply to . . . any blanket or group policy of
33 insurance] except as provided in Subsections . . . (C)
34 of Section 2

35 Revisor's Note

36 (1) Section (C), V.T.I.C. Article 3.70-2,
37 refers to physical "handicap." The revised law
38 substitutes "disability" for "handicap" because, in
39 this context, "disability" and "handicap" are
40 synonymous, and "disability" is the term used in most
41 other contexts, including the federal Americans with
42 Disabilities Act of 1990 (42 U.S.C. Section 12101 et
43 seq.).

44 (2) Section (C), V.T.I.C. Article 3.70-2,
45 refers to "the insured." The revised law substitutes

1 "the insured or group member" to provide for
2 consistent use of terminology in this chapter in
3 relation to individual, blanket, and group insurance
4 policies.

5 Revised Law

6 Sec. 1201.060. REQUIRED DEFINITION OF "EMERGENCY CARE" IN
7 INDIVIDUAL OR GROUP POLICY. An individual or group accident and
8 health insurance policy that provides an emergency care benefit,
9 including a policy issued by a corporation operating under Chapter
10 842, must define "emergency care" as follows:

11 "Emergency care" means bona fide emergency services provided
12 after the sudden onset of a medical condition manifesting itself by
13 acute symptoms of sufficient severity, including severe pain, such
14 that the absence of immediate medical attention could reasonably be
15 expected to result in:

- 16 (1) placing the patient's health in serious jeopardy;
17 (2) serious impairment to bodily functions; or
18 (3) serious dysfunction of any bodily organ or part.

19 (V.T.I.C. Art. 3.70-2, Sec. (I).)

20 Source Law

21 (I) An individual or group policy of accident
22 and sickness insurance that provides any emergency
23 care benefit, including policies issued by companies
24 subject to Chapter 20, Insurance Code, delivered or
25 issued for delivery in this state must define
26 emergency care as follows: "Emergency care" means
27 bona fide emergency services provided after the sudden
28 onset of a medical condition manifesting itself by
29 acute symptoms of sufficient severity, including
30 severe pain, such that the absence of immediate
31 medical attention could reasonably be expected to
32 result in:

- 33 (1) placing the patient's health in
34 serious jeopardy;
35 (2) serious impairment to bodily
36 functions; or
37 (3) serious dysfunction of any bodily
38 organ or part.

39 Revised Law

40 Sec. 1201.061. COVERAGE FOR ADOPTED CHILD. (a) An
41 individual accident and health insurance policy that provides
42 coverage for an insured's immediate family or children may not,

1 solely because the insured's child is adopted:

2 (1) exclude the child from coverage; or

3 (2) limit coverage for the child.

4 (b) For the purposes of this section, a child is an
5 insured's child if the insured is a party to a suit in which the
6 insured seeks to adopt the child. (V.T.I.C. Art. 3.70-2, Sec.
7 (K).)

8 Source Law

9 (K) An accident and sickness insurance policy
10 that provides coverage for the immediate family or
11 children of a person insured under the policy may not
12 exclude from coverage or limit coverage to a child of
13 the insured solely because the child is adopted. For
14 the purposes of this subsection, a child is considered
15 to be the child of an insured if the insured is a party
16 in a suit in which the adoption of the child by the
17 insured is sought.

18 Revised Law

19 Sec. 1201.062. COVERAGE FOR CERTAIN CHILDREN IN INDIVIDUAL
20 OR GROUP POLICY OR IN PLAN OR PROGRAM. (a) An individual or group
21 accident and health insurance policy that is delivered, issued for
22 delivery, or renewed in this state, including a policy issued by a
23 corporation operating under Chapter 842, or a self-funded or
24 self-insured welfare or benefit plan or program, to the extent that
25 regulation of the plan or program is not preempted by federal law,
26 that provides coverage for a child of an insured or group member, on
27 payment of a premium, must provide coverage for:

28 (1) each grandchild of the insured or group member if
29 the grandchild is:

30 (A) unmarried;

31 (B) younger than 25 years of age; and

32 (C) a dependent of the insured or group member
33 for federal income tax purposes at the time application for
34 coverage of the grandchild is made; and

35 (2) each child for whom the insured or group member
36 must provide medical support under an order issued under Chapter
37 154, Family Code, or enforceable by a court in this state.

38 (b) Coverage for a grandchild of the insured or group member

1 may not be terminated solely because the grandchild is no longer a
2 dependent of the insured or group member for federal income tax
3 purposes. (V.T.I.C. Art. 3.70-2, Sec. (L) (part), as amended Acts
4 77th Leg., R.S., Chs. 396 and 1027.)

5 Source Law

6 (L) [as amended Acts 77th Leg., R.S., Ch. 396]
7 An individual or group policy of accident and sickness
8 insurance that is delivered, issued for delivery, or
9 renewed in this state, including a policy issued by a
10 company subject to Chapter 20, Insurance
11 Code, . . . and a self-funded or self-insured welfare
12 or benefit plan or program to the extent that
13 regulation of the plan or program is not preempted by
14 federal law that provides coverage for a child of the
15 policyholder, must provide coverage upon payment of a
16 premium for:

17 (1) any children of the policyholder's
18 child if those children are dependents of the
19 policyholder; provided that, for purposes of this
20 subdivision, a grandchild of a policyholder is a
21 dependent of the policyholder regardless of whether
22 the policyholder treats the grandchild as a dependent
23 for federal income tax purposes; or

24 (2) a child for whom the group member or
25 insured must provide medical support under an order
26 issued under Chapter 154, Family Code, or enforceable
27 by a court in this state.

28 (L) [as amended Acts 77th Leg., R.S., Ch. 1027]
29 An individual or group policy of accident and sickness
30 insurance that is delivered, issued for delivery, or
31 renewed in this state, including a policy issued by a
32 company subject to Chapter 20, Insurance
33 Code, . . . and a self-funded or self-insured welfare
34 or benefit plan or program to the extent that
35 regulation of the plan or program is not preempted by
36 federal law that provides coverage for a child of the
37 policyholder, must provide coverage upon payment of a
38 premium for any unmarried child of the policyholder's
39 child if the child is younger than 25 years of age and
40 is a dependent of the policyholder for federal income
41 tax purposes at the time application for coverage of
42 the child of the policyholder's child is made or for a
43 child for whom the group member or insured must provide
44 medical support under an order issued under Chapter
45 154, Family Code, or enforceable by a court in this
46 state. Coverage for a child of the policyholder's
47 child may not be terminated solely because the covered
48 child is no longer a dependent of the policyholder for
49 federal income tax purposes.

50 Revisor's Note

51 (1) Section (L), V.T.I.C. Article 3.70-2,
52 refers to "the policyholder" and "the group member or
53 insured." The revised law omits the reference to
54 "policyholder" and refers only to the "insured or
55 group member" to provide for consistent use of proper

1 terminology that reflects the application of the
2 section to both group and individual policies.

3 (2) Section (L), V.T.I.C. Article 3.70-2, was
4 amended twice during the 77th Legislative Session.
5 Chapter 1027, Acts of the 77th Legislature, Regular
6 Session, 2001, amended Section (L) to require coverage
7 of a grandchild of the insured or group member if the
8 grandchild is unmarried, is younger than 25 years of
9 age, and is a dependent of the insured or group member
10 for federal income tax purposes at the time
11 application for coverage of the grandchild is made.

12 Chapter 396, Acts of the 77th Legislature,
13 Regular Session, 2001, amended Section (L) to require
14 coverage of a grandchild of the insured or group member
15 if the grandchild is a dependent of the insured or
16 group member and to provide that a grandchild of the
17 insured or group member is a dependent regardless of
18 whether the insured or group member treats the
19 grandchild as a dependent for federal income tax
20 purposes.

21 It is impossible to give effect to both
22 amendments made by Chapters 396 and 1027 regarding
23 coverage for a grandchild. Under basic rules of
24 statutory construction, codified in Sections 311.025
25 and 312.014, Government Code, if it is impossible to
26 read two acts of the same legislative session together
27 so that effect may be given to both, the latest
28 enactment is read as an implied repeal of the earlier
29 act to the extent of the conflict. The last
30 legislative action on Chapter 396 occurred on May 15,
31 2001. The last legislative action on Chapter 1027
32 occurred on May 22, 2001. Under Sections 311.025 and
33 312.014, Government Code, the amendment to Section
34 (L), Article 3.70-2, made by Chapter 1027 impliedly

1 repealed the amendment adopted under Chapter 396. The
2 revised law accordingly is drafted to reflect the
3 amendment to Section (L) made by Chapter 1027 and to
4 omit the amendment to Section (L) made by Chapter 396.

5 Revised Law

6 Sec. 1201.063. PROHIBITION OF CERTAIN CRITERIA RELATING TO
7 CHILD'S COVERAGE IN INDIVIDUAL OR GROUP POLICY. Regarding a
8 natural or adopted child of an insured or group member or a child
9 for whom the insured or group member must provide medical support
10 under an order issued under Chapter 154, Family Code, or
11 enforceable by a court in this state, an individual or group
12 accident and health insurance policy that provides coverage for a
13 child of an insured or group member may not set a different premium
14 for the child, exclude the child from coverage, or discontinue
15 coverage of the child because:

16 (1) the child does not reside with the insured or group
17 member; or

18 (2) the insured or group member does not claim the
19 child as an exemption for federal income tax purposes under Section
20 151(c)(1)(B), Internal Revenue Code of 1986. (V.T.I.C.
21 Art. 3.70-2, Sec. (M)(1).)

22 Source Law

23 (M)(1) A group or individual accident and
24 sickness insurance policy that provides coverage for
25 children of a group member or a person insured under
26 the policy may not exclude from or discontinue
27 coverage or set a different premium for the natural
28 born or adopted child of the group member or person
29 insured or for a child for whom the group member or
30 insured must provide medical support under an order
31 issued under Chapter 154, Family Code, or enforceable
32 by a court in this state for either of the following
33 reasons:

34 (a) the child does not reside with
35 the group member or insured; or

36 (b) the group member or insured does
37 not claim the child as an exemption for federal income
38 tax purposes under Section 151(c)(1)(B), Internal
39 Revenue Code of 1986 (26 U.S.C. Section 151(c)(1)(B)).

40 Revisor's Note

41 Section (M)(1), V.T.I.C. Article 3.70-2, refers
42 to a "person insured." For consistency throughout the

1 code, the revised law refers to an "insured." Similar
2 changes have been made throughout this chapter.

3 Revised Law

4 Sec. 1201.064. COVERAGE FOR CHILD OF SPOUSE IN INDIVIDUAL
5 OR GROUP POLICY. An individual or group accident and health
6 insurance policy that provides coverage for a child of an insured or
7 group member may not:

8 (1) set a premium for a child that is different from
9 the premium for other children because the child is the natural or
10 adopted child of the spouse of the insured or group member;

11 (2) exclude a child described by Subdivision (1) from
12 coverage; or

13 (3) discontinue coverage of a child described by
14 Subdivision (1). (V.T.I.C. Art. 3.70-2, Sec. (M)(2).)

15 Source Law

16 (2) A group or individual accident and
17 sickness insurance policy that provides coverage for
18 children of a group member or a person insured under
19 the policy may not exclude from or discontinue
20 coverage or set a different premium for the natural
21 born or adopted child of the spouse of the group member
22 or person insured.

23 Revised Law

24 Sec. 1201.065. AGE AND SCHOOL ENROLLMENT ELIGIBILITY
25 CRITERIA FOR DEPENDENT CHILDREN IN INDIVIDUAL OR GROUP POLICY; LATE
26 ENROLLMENT. (a) An individual or group accident and health
27 insurance policy may contain criteria relating to a maximum age or
28 enrollment in school to establish continued eligibility for
29 coverage of a child younger than 25 years of age.

30 (b) In the case of a late enrollment, an insurer may require
31 evidence of insurability that is satisfactory to the insurer before
32 a child is included for coverage under the policy. (V.T.I.C.
33 Art. 3.70-2, Sec. (M)(3).)

34 Source Law

35 (3) Other policy provisions relating to
36 maximum limiting attained age and enrollment in school
37 may be used to establish continued eligibility for
38 coverage of a child less than 25 years of age. In the
39 event of late enrollment, the insurance company may

1 require evidence of insurability satisfactory to the
2 company before inclusion of the child for coverage
3 under the policy.

4 [Sections 1201.066-1201.100 reserved for expansion]

5 SUBCHAPTER C. GENERAL POLICY STANDARDS AND PROVISIONS

6 Revised Law

7 Sec. 1201.101. STANDARDS FOR POLICY PROVISIONS. (a) The
8 commissioner shall adopt reasonable rules establishing specific
9 standards for:

10 (1) the content of an individual accident and health
11 insurance policy; and

12 (2) the manner of sale of an individual accident and
13 health insurance policy, including disclosures required to be made
14 in connection with the sale.

15 (b) Rules adopted under this section must establish
16 standards for:

17 (1) policy readability; and

18 (2) full and fair policy disclosures.

19 (c) Standards established under this section may include
20 standards that address:

21 (1) terms of policy renewability;

22 (2) initial and subsequent conditions of eligibility;

23 (3) nonduplication of coverage;

24 (4) coverage of dependents;

25 (5) preexisting conditions;

26 (6) termination of insurance;

27 (7) probationary periods;

28 (8) limitations;

29 (9) exceptions;

30 (10) reductions;

31 (11) elimination periods;

32 (12) requirements for replacement;

33 (13) recurrent conditions; and

34 (14) definitions of terms, including definitions of:

35 (A) "accident";

- 1 (B) "accidental means";
- 2 (C) "guaranteed renewable and noncancellable";
- 3 (D) "hospital";
- 4 (E) "injury";
- 5 (F) "nervous disorder";
- 6 (G) "partial disability";
- 7 (H) "physician";
- 8 (I) "sickness"; and
- 9 (J) "total disability."

10 (d) A definition of "hospital" adopted under Subsection (c)
11 may not apply to a corporation operating under Chapter 842.
12 (V.T.I.C. Art. 3.70-1, Sec. (E)(1).)

13 Source Law

14 (E) Standards for Policy Provisions. (1) The
15 Board shall issue reasonable rules and regulations to
16 establish specific standards including standards for
17 readability of policies and for full and fair
18 disclosure, that set forth the manner, content, and
19 required disclosure for the sale of individual
20 policies of accident and sickness insurance which
21 shall be in addition to and in accordance with
22 applicable laws of this state which may cover but shall
23 not be limited to:

- 24 (a) terms of renewability;
- 25 (b) initial and subsequent
- 26 conditions of eligibility;
- 27 (c) nonduplication of coverage
- 28 provisions;
- 29 (d) coverage of dependents;
- 30 (e) pre-existing conditions;
- 31 (f) termination of insurance;
- 32 (g) probationary periods;
- 33 (h) limitations;
- 34 (i) exceptions;
- 35 (j) reductions;
- 36 (k) elimination periods;
- 37 (l) requirements for replacement;
- 38 (m) recurrent conditions; and
- 39 (n) the definition of terms including

40 but not limited to the following: hospital, accident,
41 sickness, injury, physician, accidental means, total
42 disability, partial disability, nervous disorder,
43 guaranteed renewable and noncancellable; provided
44 that any definition of hospital so developed shall not
45 be applicable to companies organized under Chapter 20
46 of this code, as amended.

47 Revisor's Note

48 Section (E)(1), V.T.I.C. Article 3.70-1,
49 provides that rules adopted under that section "shall
50 be in addition to and in accordance with applicable

1 laws of this state." The revised law omits the quoted
2 language as unnecessary. The phrase "shall be in
3 addition to" is unnecessary because an accepted
4 general principle of statutory construction requires
5 that a statute and rules adopted under a statute be
6 given cumulative effect with other statutes unless the
7 statute provides otherwise or unless the statute or
8 rule conflicts with another statute. The general
9 principle applies to the revised law. The phrase
10 "shall be . . . in accordance with applicable laws of
11 this state" is unnecessary because rules may not
12 conflict with statutes under general legal principles,
13 and a statement to that effect is unnecessary.

14 Revised Law

15 Sec. 1201.102. PROHIBITION OF POLICY PROVISIONS. The
16 commissioner may adopt rules prohibiting specific individual
17 accident and health insurance policy provisions not specifically
18 authorized by statute that the commissioner determines are unjust,
19 unfair, or unfairly discriminatory to:

- 20 (1) the policyholder;
- 21 (2) an insured under the policy; or
- 22 (3) a beneficiary. (V.T.I.C. Art. 3.70-1, Sec.
23 (E)(2).)

24 Source Law

25 (2) The Board may issue rules and
26 regulations that specify prohibited policy
27 provisions, not otherwise specifically authorized by
28 statute, which in the opinion of the Board are unjust,
29 unfair, or unfairly discriminatory to the
30 policyholder, any person insured under the policy, or
31 beneficiary.

32 Revised Law

33 Sec. 1201.103. COMPLIANCE WITH MINIMUM STANDARDS FOR
34 BENEFITS. (a) An individual accident and health insurance policy
35 must meet the minimum standards for benefits established under
36 Section 1201.104 for each category of coverage provided under the
37 policy.

1 (b) Subsection (a) does not apply if the commissioner
2 determines that the policy is a supplemental policy or experimental
3 policy or determines that the policy will fulfill a reasonable
4 public need and the policy meets the requirements of Chapter 1701.
5 (V.T.I.C. Art. 3.70-1, Sec. (F)(3).)

6 Source Law

7 (3) No policy shall be issued, or issued
8 for delivery, in the State of Texas which does not meet
9 the prescribed minimum standards for the categories of
10 coverage listed in Paragraphs (a) through (h) of
11 Subsection (1) of this section which are contained
12 within the policy unless the Board finds such policy to
13 be a supplemental policy, a policy experimental in
14 nature or finds such policy will fulfill a reasonable
15 public need and such policy meets the requirements set
16 forth in Article 3.42 of the Insurance Code.

17 Revised Law

18 Sec. 1201.104. MINIMUM STANDARDS FOR BENEFITS. (a) For
19 individual accident and health insurance policies, the
20 commissioner shall adopt rules establishing minimum standards for
21 benefits under each of the following categories of coverage:

- 22 (1) basic hospital expense;
23 (2) basic medical-surgical expense;
24 (3) hospital confinement indemnity;
25 (4) major medical expense;
26 (5) disability income protection;
27 (6) accident only;
28 (7) specified disease;
29 (8) specified accident; and
30 (9) limited benefit.

31 (b) This section does not prohibit the issuance of an
32 individual accident and health insurance policy that combines
33 categories of coverage listed by this section. (V.T.I.C.
34 Art. 3.70-1, Secs. (F)(1), (2).)

35 Source Law

36 (F) Minimum Standards for Benefits. (1) The
37 Board shall issue rules and regulations to establish
38 minimum standards for benefits under each of the
39 following categories of coverage in individual
40 policies of accident and sickness insurance:

- 41 (a) basic hospital expense coverage;

1 (b) basic medical-surgical expense
2 coverage;
3 (c) hospital confinement indemnity
4 coverage;
5 (d) major medical expense coverage;
6 (e) disability income protection
7 coverage;
8 (f) accident only coverage;
9 (g) specified disease or specified
10 accident coverage; and
11 (h) limited benefit coverage.

12 (2) Nothing in this section shall preclude
13 the issuance of any policy which combines two or more
14 of the categories of coverage enumerated in Paragraphs
15 (a) through (h) of Subsection (1) of this section.

16 Revised Law

17 Sec. 1201.105. MINIMUM STANDARDS FOR BENEFITS FOR LONG-TERM
18 CARE IN INDIVIDUAL, GROUP, OR BLANKET POLICY. (a) The commissioner
19 shall adopt rules establishing minimum standards for benefits for
20 long-term care coverage under individual, group, and blanket
21 accident and health insurance policies and certificates delivered
22 or issued for delivery in this state.

23 (b) Rules adopted under this section apply to group
24 coverages delivered or issued for delivery by a corporation
25 operating under Chapter 842. (V.T.I.C. Art. 3.70-1, Sec. (F)(5)
26 (part); Art. 3.70-8, Sec. (a) (part).)

27 Source Law

28 [Art. 3.70-1, Sec. (F)]
29 (5) The Board shall adopt rules and
30 regulations establishing minimum standards for
31 benefits for long-term care coverage under individual
32 and group policies and certificates of accident and
33 sickness insurance delivered or issued for delivery in
34 this state including group coverages delivered or
35 issued for delivery by companies subject to Chapter 20
36 of this code and

37 Art. 3.70-8. (a) [Nothing in this Act shall
38 apply to . . . any blanket or group policy of
39 insurance] except as provided in . . . Subdivision (5)
40 of Subsection (F) of Section 1 and

41 Revised Law

42 Sec. 1201.106. IDENTIFICATION OF POLICIES ACCORDING TO
43 COVERAGE PROVIDED. The commissioner shall prescribe the method to
44 identify an individual accident and health insurance policy
45 according to the coverages the policy provides. (V.T.I.C.
46 Art. 3.70-1, Sec. (F)(4).)

1 Source Law

2 (4) The Board shall prescribe the method
3 of identification of policies based on coverages
4 provided.

5 Revised Law

6 Sec. 1201.107. OUTLINE OF COVERAGE REQUIRED. (a) An
7 outline of coverage for an individual accident and health insurance
8 policy must be delivered to the applicant at the time application is
9 made, and an acknowledgment of receipt or certificate of delivery
10 of an outline of coverage must be provided to the insurer with the
11 application.

12 (b) If the policy issued differs from the policy for which
13 the applicant applied, an outline of coverage that properly
14 describes the policy must:

15 (1) accompany the policy when delivered; and

16 (2) clearly state that the policy is not the policy for
17 which the applicant applied.

18 (c) Subsection (a) does not apply to a direct response
19 insurance product.

20 (d) An outline of coverage under a direct response insurance
21 product must accompany the policy. (V.T.I.C. Art. 3.70-1, Sec.
22 (G)(1).)

23 Source Law

24 (G) Outline of Coverage. (1) In order to
25 provide for full and fair disclosure in the sale of
26 individual accident and sickness insurance policies,
27 no such policy shall be delivered, or issued for
28 delivery, in the State of Texas unless: (i) in the
29 case of a direct response insurance product, the
30 outline of coverage described in Subsection (2) of
31 this section accompanies the policy; (ii) in all other
32 cases, the outline of coverage described in Subsection
33 (2) of this section is delivered to the applicant at
34 the time application is made and an acknowledgment of
35 receipt or certificate of delivery of such outline is
36 provided the insurer with the application. In the
37 event the policy is issued on a basis other than that
38 applied for, the outline of coverage properly
39 describing the policy must accompany the policy when
40 it is delivered and clearly state that it is not the
41 policy for which application was made.

42 Revisor's Note

43 Section (G)(1), V.T.I.C. Article 3.70-1,
44 provides restrictions on the delivery or issuance of

1 insurance policies "[i]n order to provide for full and
2 fair disclosure in the sale of individual accident and
3 sickness insurance policies." The revised law omits
4 the quoted language relating to the purpose of the
5 article as unnecessary because it duplicates language
6 relating to the purpose of the entire act in Section
7 (A), V.T.I.C. Article 3.70-1, revised as Section
8 1201.002.

9 Revised Law

10 Sec. 1201.108. FORMAT AND CONTENT OF OUTLINE OF
11 COVERAGE. (a) In this section, "format" means style,
12 arrangement, and overall appearance, including:

- 13 (1) the size, color, and prominence of type; and
14 (2) the arrangement of text and captions.

15 (b) The commissioner shall prescribe the format and content
16 of an outline of coverage required by Section 1201.107.

17 (c) An outline of coverage must include:

18 (1) a statement that identifies the applicable
19 categories of coverage listed by Section 1201.104 and provided by
20 the policy;

21 (2) a description of the principal benefits and
22 coverage provided by the policy;

23 (3) a statement of the exceptions, reductions, and
24 limitations in the policy;

25 (4) a statement of the renewal provision, including
26 any reservation of the insurer's right to change premiums;

27 (5) a statement that:

28 (A) the outline is a summary of the policy issued
29 or applied for; and

30 (B) the policy should be consulted to determine
31 governing contractual provisions;

32 (6) as the commissioner determines necessary to carry
33 out the purposes of this chapter, a summary of the provisions
34 required by Subchapter E to be in the policy; and

1 (7) any other statement, description, or outline that
2 the commissioner determines is reasonably necessary to carry out
3 the purposes of this chapter. (V.T.I.C. Art. 3.70-1, Sec. (G)(2).)

4 Source Law

5 (2) The Board shall prescribe the format
6 and content of the outline of coverage required by
7 Subsection (1) of this section. "Format" means style,
8 arrangement, and overall appearance, including such
9 items as the size, color, and prominence of type and
10 the arrangement of text and captions. Such outline of
11 coverage shall include:

12 (a) a statement identifying the
13 applicable category or categories of coverage provided
14 by the policy as prescribed in Section (F) of this
15 article;

16 (b) a description of the principal
17 benefits and coverage provided in the policy;

18 (c) a statement of the exceptions,
19 reductions, and limitations contained in the policy;

20 (d) a statement of the renewal
21 provision including any reservation by the insurer of
22 a right to change premiums;

23 (e) a statement that the outline is a
24 summary of the policy issued or applied for and that
25 the policy should be consulted to determine governing
26 contractual provisions;

27 (f) a summary of such provisions
28 required to be in the policy by Section 3, Chapter 397,
29 Acts of the 54th Legislature, Regular Session, 1955,
30 as amended (Article 3.70-3, Vernon's Texas Insurance
31 Code), as the Board may determine to be necessary to
32 carry out the purposes of this Act.

33 (g) Any other statements,
34 descriptions, or outlines that the Board may determine
35 to be reasonably necessary to carry out the purposes of
36 this Act.

37 [Sections 1201.109-1201.150 reserved for expansion]

38 SUBCHAPTER D. PREEXISTING CONDITIONS

39 Revised Law

40 Sec. 1201.151. COMPLIANCE WITH SUBCHAPTER; PROHIBITION OF
41 DEFENSE. Except as provided by this subchapter, an individual
42 accident and health insurance policy may not include a provision
43 that permits a defense based on a preexisting condition. (V.T.I.C.
44 Art. 3.70-1, Sec. (H)(3).)

45 Source Law

46 (3) Except as so provided, a policy issued
47 under the provisions of this section may not include
48 wording that would permit a defense based on
49 pre-existing conditions.

50 Revised Law

51 Sec. 1201.152. COVERAGE UNDER SIMPLIFIED APPLICATION

1 FORM. (a) Notwithstanding Clause (b) of the provision required
2 by Section 1201.208(a), an individual accident and health insurance
3 policy must cover any loss that occurs after 12 months from a
4 preexisting condition if the insurer uses a simplified application
5 form that does not include a question concerning the applicant's
6 health history or medical treatment history.

7 (b) This section applies regardless of whether the
8 simplified application form includes a question regarding the
9 applicant's health at the time of application.

10 (c) This section does not require an insurer to cover a loss
11 from a condition that the policy specifically excludes from
12 coverage. (V.T.I.C. Art. 3.70-1, Sec. (H)(1).)

13 Source Law

14 (H) Pre-existing Conditions. (1) Notwithstanding
15 the provisions of Section 3(A)(2)(b), Chapter 397,
16 Acts of the 54th Legislature, Regular Session, 1955,
17 as amended (Article 3.70-3, Vernon's Texas Insurance
18 Code), if an insurer elects to use a simplified
19 application form, with or without a question as to the
20 applicant's health at the time of application, but
21 without any questions concerning the insured's health
22 history or medical treatment history, the policy must
23 cover any loss occurring after 12 months from any
24 pre-existing condition not specifically excluded from
25 coverage by terms of the policy.

26 Revised Law

27 Sec. 1201.153. COVERAGE FOR INDIVIDUALS AGE 65 OR OLDER.

28 (a) Notwithstanding Section 1201.152 or Clause (b) of the
29 provision required by Section 1201.208(a), an individual accident
30 and health insurance policy delivered or issued for delivery to an
31 individual who is 65 years of age or older may not include a
32 provision that excludes from coverage a loss that occurs from a
33 preexisting condition more than six months after the effective date
34 of coverage under the policy.

35 (b) Notwithstanding Subsection (a), the commissioner may
36 authorize a policy provision that excludes coverage for a
37 preexisting condition for a period of not more than one year if the
38 commissioner determines that the provision would serve the public
39 interest.

1 (c) This section does not require an insurer to provide
2 coverage for a loss from a preexisting condition specifically
3 excluded from coverage by name or specific description in an
4 exclusion endorsement or rider that is effective on the date of the
5 loss. (V.T.I.C. Art. 3.70-1, Sec. (H)(2).)

6 Source Law

7 (2) Notwithstanding the provisions of
8 Section 3(A)(2)(b), Chapter 397, Acts of the 54th
9 Legislature, Regular Session, 1955, as amended
10 (Article 3.70-3, Vernon's Texas Insurance Code), or of
11 Paragraph (1) of this subsection, no individual policy
12 of accident and sickness insurance delivered or issued
13 for delivery in this state to a person age 65 or over
14 may contain a provision excluding from coverage any
15 loss due to a pre-existing condition, not specifically
16 excluded from coverage by name or specific description
17 in an exclusion endorsement or rider effective on the
18 date of the loss, for a period in excess of six months
19 from the effective date of coverage under the policy;
20 provided, however, that if the Board finds that the
21 public interest would be served thereby, it may
22 authorize a policy provision excluding coverage for
23 pre-existing conditions for a period in excess of six
24 months but in no event shall such period exceed one
25 year.

26 Revised Law

27 Sec. 1201.154. COVERAGE FOR CERTAIN PREVIOUSLY COVERED
28 PERSONS. (a) In this section, "creditable coverage" has the
29 meaning assigned by Section 1205.004.

30 (b) A preexisting condition provision in an individual
31 accident and health insurance policy may not apply to an
32 individual:

33 (1) who was continuously covered for an aggregate
34 period of 18 months by creditable coverage that was in effect up to
35 a date not more than 63 days before the effective date of the
36 individual coverage, excluding any waiting period; and

37 (2) whose most recent creditable coverage was under:

38 (A) a group health plan;

39 (B) a governmental plan; or

40 (C) a church plan.

41 (c) In determining whether a preexisting condition
42 provision of an individual accident and health insurance policy
43 applies to an individual, an insurer shall credit the time the

1 individual previously was covered under creditable coverage if the
2 previous coverage was in effect at any time during the 18 months
3 preceding the effective date of the individual coverage. (V.T.I.C.
4 Art. 3.70-1, Sec. (H)(4).)

5 Source Law

6 (4)(a) A preexisting condition provision
7 in an individual health insurance policy shall not
8 apply to an individual who was continuously covered
9 for an aggregate period of 18 months by creditable
10 coverage that was in effect up to a date not more than
11 63 days before the effective date of the individual
12 coverage, excluding any waiting period, and whose most
13 recent creditable coverage was under a group health
14 plan, governmental plan, or church plan.

15 (b) For purposes of this section,
16 creditable coverage means coverage under any of the
17 following: a self-funded or self-insured employee
18 welfare benefit plan that provides health benefits and
19 is established in accordance with the Employee
20 Retirement Income Security Act of 1974 (29 U.S.C.
21 Section 1001 et seq.); any group or individual health
22 benefit plan provided by a health insurance carrier or
23 health maintenance organization; Part A or Part B of
24 Title XVIII of the Social Security Act; Title XIX of
25 the Social Security Act, other than coverage
26 consisting solely of benefits under Section 1928;
27 Chapter 55 of Title 10, United States Code; a medical
28 care program of the Indian Health Service or of a
29 tribal organization; a state health benefits risk
30 pool; a health plan offered under Chapter 89 of Title
31 5, United States Code; a public health plan as defined
32 by federal regulations; or a health benefit plan under
33 Section 5(e) of the Peace Corps Act (22 U.S.C. Section
34 2504(e)).

35 (c) In determining whether a
36 preexisting condition provision applies to an
37 individual, the individual insurance carrier shall
38 credit the time the individual was previously covered
39 under creditable coverage if the previous coverage was
40 in effect at any time during the 18 months preceding
41 the effective date of the individual coverage.

42 Revisor's Note

43 (1) Section (H)(4)(a), V.T.I.C. Article 3.70-1,
44 refers to "an individual health insurance policy."
45 The revised law substitutes for the quoted language
46 "an individual accident and health insurance policy"
47 to provide consistency in terminology and because the
48 context of the reference makes it clear that the quoted
49 language refers to an individual accident and health
50 insurance policy.

51 (2) Section (H)(4)(b), V.T.I.C. Article 3.70-1,

1 defines "creditable coverage." That definition of
2 "creditable coverage" was adopted by Chapter 837, Acts
3 of the 75th Legislature, Regular Session, 1997. A
4 substantially identical definition, containing
5 exclusions not explicitly made applicable in Article
6 3.70-1, appeared three times in Chapter 955, Acts of
7 the 75th Legislature, Regular Session, 1997, in
8 sections amending V.T.I.C. Chapter 26, adding V.T.I.C.
9 Article 21.52G, and adding V.T.I.C. Article 3.95-1.5.
10 The intent of the legislature in enacting Chapters 837
11 and 955 was to implement federal requirements on
12 health insurance portability and availability; the use
13 of similar definitions in four different articles was
14 to ensure compliance with the federal requirements.
15 The relevant portion of the definition contained in
16 V.T.I.C. Article 21.52G is revised in this code in
17 Section 1205.004. Therefore, to avoid unnecessary
18 duplication, the revised law substitutes a
19 cross-reference to Section 1205.004 for the substance
20 of Section (H)(4)(b), Article 3.70-1.

21 [Sections 1201.155-1201.200 reserved for expansion]

22 SUBCHAPTER E. REQUIRED POLICY PROVISIONS

23 Revised Law

24 Sec. 1201.201. POLICY PROVISIONS REQUIRED. (a) Except as
25 provided by Subsections (b) and (c), an individual accident and
26 health insurance policy must contain the provisions required by
27 this subchapter in the words provided by this subchapter.

28 (b) An insurer may substitute for a policy provision
29 required by this subchapter a provision with different wording
30 approved by the commissioner in accordance with reasonable rules
31 adopted by the commissioner. A substituted provision may not be
32 less favorable to an insured or a beneficiary of the policy than the
33 provision required by this subchapter.

34 (c) If a policy provision required by this subchapter is

1 wholly or partly inapplicable to or inconsistent with the coverage
2 provided by a particular form of policy, the insurer, with the
3 commissioner's approval, shall:

4 (1) omit from the policy each inapplicable provision
5 or part of a provision; and

6 (2) modify each inconsistent provision or part of a
7 provision so that the provision as contained in the policy is
8 consistent with the coverage provided by the policy.

9 (d) A policy provision required by this subchapter must be
10 preceded by the caption for the provision provided by this
11 subchapter or, at the option of the insurer, by an appropriate
12 individual or group caption or subcaption approved by the
13 commissioner. (V.T.I.C. Art. 3.70-3, Secs. (A) (part), (B) (part),
14 (C).)

15 Source Law

16 Art. 3.70-3. (A) Required Provisions. Except
17 as provided in paragraph (C) of this section each such
18 policy delivered or issued for delivery to any person
19 in this state shall contain the provisions specified
20 in this subsection in the words in which the same
21 appear in this section; provided, however, that the
22 insurer may, at its option, substitute for one or more
23 of such provisions, provisions of different wording
24 approved by the Board, in accordance with reasonable
25 rules and regulations promulgated by the Board, which
26 are in each instance not less favorable in any respect
27 to the insured or the beneficiary; and Such
28 provisions shall be preceded individually by the
29 caption appearing in this subsection or, at the option
30 of the insurer, by such appropriate individual or
31 group captions or subcaptions as the Board may
32 approve.

33
34 (B) Other Provisions. Except as provided in
35 paragraph (C) of this section, no such policy
36 delivered or issued for delivery to any person in this
37 state shall contain provisions respecting the matters
38 set forth below unless such provisions are in the words
39 in which the same appear in this section; provided,
40 however, that the insurer may, at its option, use in
41 lieu of any such provision a provision of different
42 wording approved by the Board, in accordance with
43 reasonable rules and regulations promulgated by the
44 Board, which is not less favorable in any respect to
45 the insured or the beneficiary. Any such provision
46 contained in the policy shall be preceded individually
47 by the appropriate caption appearing in this
48 subsection or, at the option of the insurer, by such
49 appropriate individual or group captions or
50 subcaptions as the Board may approve.

51
52 (C) Inapplicable or Inconsistent Provisions. If

1 any provision of this section is in whole or in part
2 inapplicable to or inconsistent with the coverage
3 provided by a particular form of policy the insurer,
4 with the approval of the Board, shall omit from such
5 policy any inapplicable provision or part of a
6 provision, and shall modify any inconsistent provision
7 or part of the provision in such manner as to make the
8 provision as contained in the policy consistent with
9 the coverage provided by the policy.

10 Revised Law

11 Sec. 1201.202. ORDER OF REQUIRED POLICY
12 PROVISIONS. (a) Except as provided by Subsection (b), policy
13 provisions required by this subchapter or corresponding substitute
14 provisions must be printed in the same consecutive order as
15 provided by this subchapter.

16 (b) An insurer may print a policy provision required by this
17 subchapter or a corresponding substitute provision as a unit in any
18 part of the policy with other provisions to which the provision is
19 logically related.

20 (c) A policy printed under Subsection (b) may not be wholly
21 or partly unintelligible, uncertain, ambiguous, abstruse, or
22 likely to mislead a person to whom the policy is offered, delivered,
23 or issued. (V.T.I.C. Art. 3.70-3, Sec. (D).)

24 Source Law

25 (D) Order of Certain Policy Provisions. The
26 provisions which are the subject of subsections (A)
27 and (B) of this section, or any corresponding
28 provisions which are used in lieu thereof in
29 accordance with such subsections, shall be printed in
30 the consecutive order of the provisions in such
31 subsections or, at the option of the insurer, any such
32 provision may appear as a unit in any part of the
33 policy, with other provisions to which it may be
34 logically related, provided the resulting policy shall
35 not be in whole or in part unintelligible, uncertain,
36 ambiguous, abstruse, or likely to mislead a person to
37 whom the policy is offered, delivered or issued.

38 Revised Law

39 Sec. 1201.203. OTHER POLICY PROVISIONS. A policy
40 provision that is not otherwise subject to this subchapter may not
41 make an individual accident and health insurance policy or any
42 portion of the policy less favorable in any way to the insured or
43 the beneficiary than the policy provisions that are subject to this
44 chapter. (V.T.I.C. Art. 3.70-4, Sec. (A).)

1 Source Law

2 Art. 3.70-4. (A) Other Policy Provisions. No
3 policy provision which is not subject to Section 3 of
4 this Act shall make a policy, or any portion thereof,
5 less favorable in any respect to the insured or the
6 beneficiary than the provisions thereof which are
7 subject to this Act.

8 Revised Law

9 Sec. 1201.204. POLICY PROVISIONS REQUIRED BY OTHER
10 JURISDICTION. An individual accident and health insurance policy
11 of a foreign or alien insurer may contain any provision that is:

12 (1) not less favorable to the insured or the
13 beneficiary than the provisions of this chapter; and

14 (2) prescribed or required by the law of the state
15 under which the insurer is organized. (V.T.I.C. Art. 3.70-3, Sec.
16 (F)(1).)

17 Source Law

18 (F) Requirements of other Jurisdictions. (1)
19 Any policy of a foreign or alien insurer, when
20 delivered or issued for delivery to any person in this
21 state, may contain any provision which is not less
22 favorable to the insured or the beneficiary than the
23 provisions of this Act and which is prescribed or
24 required by the law of the state under which the
25 insurer is organized.

26 Revised Law

27 Sec. 1201.205. POLICY PROVISIONS FOR POLICY DELIVERED
28 OUTSIDE THIS STATE. An individual accident and health insurance
29 policy issued by a domestic insurer for delivery in another state or
30 country may contain any provision permitted or required by the laws
31 of that state or country. (V.T.I.C. Art. 3.70-3, Sec. (F)(2).)

32 Source Law

33 (2) Any policy of a domestic insurer may,
34 when issued for delivery in any other state or country,
35 contain any provision permitted or required by the
36 laws of such other state or country.

37 Revised Law

38 Sec. 1201.206. FILING PROCEDURE. (a) The commissioner
39 may adopt reasonable rules regarding the procedure for submitting
40 policies subject to this chapter that are necessary, proper, or
41 advisable for the administration of this chapter.

42 (b) This section does not limit any authority otherwise

1 granted by law to the commissioner or department. (V.T.I.C. Art.
2 3.70-3, Sec. (G).)

3 Source Law

4 (G) Filing Procedure. The Board may make such
5 reasonable rules and regulations concerning the
6 procedure for the filing or submission of policies
7 subject to this Act as are necessary, proper or
8 advisable to the administration of this Act. This
9 provision shall not abridge any other authority
10 granted the Board by law.

11 Revised Law

12 Sec. 1201.207. POLICY PROVISION: ENTIRETY OF CONTRACT;
13 POLICY CHANGES. An individual accident and health insurance policy
14 must contain the following provision:

15 "Entire Contract; Changes: This policy, including the
16 endorsements and the attached papers, if any, constitutes the
17 entire contract of insurance. A change in this policy is not valid
18 until the change is approved by an executive officer of the insurer
19 and unless the approval is endorsed on or attached to the policy.
20 An agent does not have authority to change this policy or to waive
21 any of its provisions." (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

22 Source Law

23 (A) . . . each such policy . . . shall contain
24 the provisions specified in this subsection

25 (1) A provision as follows:

26 Entire Contract; Changes: This policy,
27 including the endorsements and the attached papers, if
28 any, constitutes the entire contract of insurance. No
29 change in this policy shall be valid until approved by
30 an executive officer of the insurer and unless such
31 approval be endorsed hereon or attached hereto. No
32 agent has authority to change this policy or to waive
33 any of its provisions.

34 . . .

35 Revisor's Note

36 Sections (A) and (B), V.T.I.C. Article 3.70-3,
37 provide that certain policies must contain specified
38 provisions "in the words in which the same appear in
39 this section." Consequently, in this subchapter,
40 beginning with this section, the revised law makes
41 only limited nonsubstantive changes to the wording as
42 necessary to accomplish in a minimal way the purposes

1 of the codification process.

2 Revised Law

3 Sec. 1201.208. POLICY PROVISION: INCONTESTABILITY. (a)
4 Except as provided by Subsection (c), an individual accident and
5 health insurance policy must contain the following provision:

6 "Time Limit on Certain Defenses: (a) After the second
7 anniversary of the date this policy is issued, a misstatement,
8 other than a fraudulent misstatement, made by the applicant in the
9 application for the policy may not be used to void the policy or to
10 deny a claim for loss incurred or disability (as defined in the
11 policy) beginning after that anniversary.

12 "(b) A claim for loss incurred or disability (as defined in
13 the policy) beginning after the second anniversary of the date this
14 policy is issued may not be reduced or denied on the ground that a
15 disease or physical condition not excluded from coverage by name or
16 specific description effective on the date of loss existed before
17 the effective date of coverage of this policy."

18 (b) Clause (a) of the provision required by Subsection (a)
19 does not:

20 (1) affect any legal requirement for avoidance of a
21 policy or denial of a claim during the initial two-year period; or

22 (2) limit the application of Section 1201.219,
23 1201.220, or 1201.221 in a case of a misstatement regarding age,
24 occupation, or other insurance.

25 (c) For a policy that provides that the insured is entitled
26 to continue the policy in force by the timely payment of premiums
27 until the insured reaches at least 50 years of age or, if the policy
28 was issued after the insured reached 44 years of age, until at least
29 the fifth anniversary of the policy's date of issuance, an insurer
30 may use the following clause instead of Clause (a) of the provision
31 required by Subsection (a):

32 "After this policy has been in force for a period of two years
33 during the lifetime of the insured (excluding any period during
34 which the insured is disabled), it shall become incontestible as to

1 the statements contained in the application."

2 (d) The provision provided by Subsection (c) must be under
3 the caption "Incontestable." An insurer that uses the provision
4 may omit the parenthetical clause. (V.T.I.C. Art. 3.70-3, Sec. (A)
5 (part).)

6 Source Law

7 (A) . . . each such policy . . . shall contain
8 the provisions specified in this subsection

9 . . .
10 (2) A provision as follows:

11 Time Limit on Certain Defenses: (a) After
12 two years from the date of issue of this policy no
13 misstatements, except fraudulent misstatements, made
14 by the applicant in the application for such policy
15 shall be used to void the policy or to deny a claim for
16 loss incurred or disability (as defined in the policy)
17 commencing after the expiration of such two-year
18 period.

19 (The foregoing policy provision shall not be so
20 construed as to affect any legal requirement for
21 avoidance of a policy or denial of a claim during such
22 initial two-year period, nor to limit the application
23 of Section 3(B), (1), (2), (3), (4), and (5) in the
24 event of misstatement with respect to age or
25 occupation or other insurance.)

26 (A policy which the insured has the right to
27 continue in force subject to its terms by the timely
28 payment of premium (1) until at least age 50 or, (2) in
29 the case of a policy issued after age 44, for at least
30 five years from its date of issue, may contain in lieu
31 of the foregoing the following provision (from which
32 the clause in parentheses may be omitted at the
33 insurer's option) under the caption "incontestible":

34 After this policy has been in force for a period
35 of two years during the lifetime of the insured
36 (excluding any period during which the insured is
37 disabled), it shall become incontestible as to the
38 statements contained in the application.)

39 (b) No claim for loss incurred or
40 disability (as defined in the policy) commencing after
41 two years from the date of issue of this policy shall
42 be reduced or denied on the ground that a disease or
43 physical condition not excluded from coverage by name
44 or specific description effective on the date of loss
45 had existed prior to the effective date of coverage of
46 this policy.

47 . . .

48 Revisor's Note

49 Section (A)(2), V.T.I.C. Article 3.70-3, states
50 that the policy provision provided by that section
51 does not limit the application of "Section 3(B), (1),
52 (2), (3), (4), and (5) in the event of misstatement
53 with respect to age or occupation or other insurance"
54 (Sections (B)(1)-(5), V.T.I.C. Article 3.70-3). When

1 Article 3.70-3 was enacted by Chapter 397, Acts of the
2 54th Legislature, Regular Session, 1955, those
3 cross-references correctly referred to provisions
4 relating to age, occupation, and other insurance.
5 However, Sections (B)(4) and (5), relating to other
6 insurance, were deleted when Article 3.70-3 was
7 amended by Chapter 703, Acts of the 64th Legislature,
8 Regular Session, 1975. Section (B)(3), also relating
9 to other insurance, was retained. The legislature
10 inadvertently failed at that time to amend Section
11 (A)(2) to reflect the change to Section (B). The
12 revised law corrects the reference in Section (A)(2)
13 by referring only to Sections (B)(1)-(3), revised as
14 Sections 1201.219, 1201.220, and 1201.221.

15 Revised Law

16 Sec. 1201.209. POLICY PROVISION: GRACE PERIOD. (a) An
17 individual accident and health insurance policy must contain the
18 following provision:

19 "Grace Period: A grace period of ____ (insert appropriate
20 number) days will be granted for the payment of each premium due
21 after the first premium. During the grace period, the policy
22 continues in force."

23 (b) The number of days of the grace period may not be less
24 than:

- 25 (1) 7 for a weekly premium policy;
26 (2) 10 for a monthly premium policy; or
27 (3) 31 for any other policy.

28 (c) A policy that contains a cancellation provision may add,
29 at the end of the provision required by Subsection (a): "subject to
30 the right of the insurer to cancel the policy in accordance with the
31 policy's cancellation provision."

32 (d) A policy in which the insurer reserves the right to
33 refuse any renewal must include the following provision at the
34 beginning of the provision required by Subsection (a):

1 "Unless, not less than five days before the premium due date,
2 the insurer has delivered to the insured, or has mailed to the
3 insured's last address as shown by the insurer's records, a written
4 notice of the insurer's intention not to renew this policy beyond
5 the period for which the premium has been accepted,"
6 (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

7 Source Law

8 (A) . . . each such policy . . . shall contain
9 the provisions specified in this subsection

10 . . .
11 (3) A provision as follows:

12 Grace Period: A grace period of
13 (insert a number not less than "7" for
14 weekly premium policies, "10" for monthly premium
15 policies, and "31" for all other policies) days will be
16 granted for the payment of each premium falling due
17 after the first premium, during which grace period the
18 policy shall continue in force.

19 (A policy which contains a cancellation provision
20 may add, at the end of the above provision, subject to
21 the right of the insurer to cancel in accordance with
22 the cancellation provision hereof.

23 A policy in which the insurer reserves the right
24 to refuse any renewal shall have, at the beginning of
25 the above provision:

26 Unless not less than five days prior to the
27 premium due date the insurer has delivered to the
28 insured or has mailed to his last address as shown by
29 the records of the insurer written notice of its
30 intention not to renew this policy beyond the period
31 for which the premium has been accepted.)
32 . . .

33 Revised Law

34 Sec. 1201.210. POLICY PROVISION: REINSTATEMENT. (a)
35 Except as provided by Subsection (b), an individual accident and
36 health insurance policy must contain the following provision:

37 "Reinstatement: If a renewal premium is not paid before the
38 expiration of the period granted for the insured to make the
39 payment, a subsequent acceptance of the premium by the insurer or
40 any agent authorized by the insurer to accept the premium, without
41 requiring in connection with the acceptance an application for
42 reinstatement, reinstates the policy. However, if the insurer or
43 authorized agent requires an application for reinstatement and
44 issues a conditional receipt for the premium tendered, the policy
45 will be reinstated on approval of the application by the insurer or,
46 if the application is not approved, on the 45th day after the date

1 of the conditional receipt unless the insurer before that date has
2 notified the insured in writing of the insurer's disapproval of the
3 application. The reinstated policy covers only loss resulting from
4 an accidental injury sustained after the date of reinstatement and
5 loss due to sickness that begins more than 10 days after the date of
6 reinstatement. In all other respects the insured and insurer have
7 the same rights under the reinstated policy as they had under the
8 policy immediately before the due date of the defaulted premium,
9 subject to any provisions endorsed in the policy or attached to the
10 policy in connection with the reinstatement. Any premium accepted
11 in connection with a reinstatement shall be applied to a period for
12 which premium has not been previously paid, but not to any period
13 more than 60 days before the date of reinstatement."

14 (b) The insurer may omit the last sentence of the provision
15 required by Subsection (a) in a policy that provides that the
16 insured is entitled to continue the policy in force by the timely
17 payment of premiums until the insured reaches at least 50 years of
18 age or, if the policy was issued after the insured reached 44 years
19 of age, until at least the fifth anniversary of the policy's date of
20 issuance. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

21 Source Law

22 (A) . . . each such policy . . . shall contain
23 the provisions specified in this subsection

24 . . .
25 (4) A provision as follows:

26 Reinstatement: If any renewal premium be
27 not paid within the time granted the insured for
28 payment, a subsequent acceptance of premium by the
29 insurer or by any agent duly authorized by the insurer
30 to accept such premium, without requiring in
31 connection therewith an application for
32 reinstatement, shall reinstate the policy; provided,
33 however, that if the insurer or such agent requires an
34 application for reinstatement and issues a conditional
35 receipt for the premium tendered, the policy will be
36 reinstated upon approval of such application by the
37 insurer or, lacking such approval, upon the
38 forty-fifth day following the date of such conditional
39 receipt unless the insurer has previously notified the
40 insured in writing of its disapproval of such
41 application. The reinstated policy shall cover only
42 loss resulting from such accidental injury as may be
43 sustained after the date of reinstatement and loss due
44 to such sickness as may begin more than ten days after
45 such date. In all other respects the insured and
46 insurer shall have the same rights thereunder as they

1 had under the policy immediately before the due date of
2 the defaulted premium, subject to any provisions
3 endorsed hereon or attached hereto in connection with
4 the reinstatement. Any premium accepted in connection
5 with a reinstatement shall be applied to a period for
6 which premium has not been previously paid, but not to
7 any period more than sixty days prior to the date of
8 reinstatement.

9 (The last sentence of the above provision
10 may be omitted from any policy which the insured has
11 the right to continue in force subject to its terms by
12 the timely payment of premium (1) until at least age 50
13 or, (2) in the case of a policy issued after age 44, for
14 at least five years from its date of issue.)
15 . . .

16 Revised Law

17 Sec. 1201.211. POLICY PROVISION: NOTICE OF CLAIM. (a)
18 Except as provided by Subsection (b), an individual accident and
19 health insurance policy must contain the following provision:

20 "Notice of Claim: A written notice of claim must be given to
21 the insurer before the 21st day after the date of the occurrence or
22 beginning of any loss covered by the policy, or as soon after that
23 date as is reasonably possible. A notice given by or on behalf of
24 the insured or the beneficiary to the insurer at _____ (insert the
25 location of any office the insurer designates for the purpose), or
26 to any authorized agent of the insurer, with information sufficient
27 to identify the insured, constitutes notice to the insurer."

28 (b) In a policy that provides a loss of time benefit that may
29 be payable for at least two years, an insurer may insert, between
30 the first and second sentences of the provision required by
31 Subsection (a), the following provision:

32 "Subject to the qualifications below, and except in the event
33 of a legal incapacity, if the insured suffers loss of time on
34 account of disability for which indemnity may be payable for at
35 least two years, the insured shall, at least once in every _____
36 (insert appropriate number) months after having given notice of
37 claim, give to the insurer notice of continuance of the disability.
38 In applying this provision, the period of _____ (insert
39 appropriate number) months following a filing of proof by the
40 insured or any payment by the insurer on account of the claim or any
41 denial of liability in whole or in part by the insurer shall be

1 excluded. Delay in giving the notice does not impair the insured's
2 right to any indemnity that would otherwise have accrued during the
3 period of _____ (insert appropriate number) months preceding the
4 date on which the notice is actually given."

5 (c) The number of months inserted in the clause permitted by
6 Subsection (b) may not be less than one or greater than six.
7 (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

8 Source Law

9 (A) . . . each such policy . . . shall contain
10 the provisions specified in this subsection

11 . . .
12 (5) A provision as follows:

13 Notice of Claim: Written notice of claim
14 must be given to the insurer within twenty days after
15 the occurrence or commencement of any loss covered by
16 the policy, or as soon thereafter as is reasonably
17 possible. Notice given by or on behalf of the insured
18 or the beneficiary to the insurer at
19 (insert the location of such office as the insurer may
20 designate for the purpose), or to any authorized agent
21 of the insurer, with information sufficient to
22 identify the insured, shall be deemed notice to the
23 insurer.

24 (In a policy providing a loss-of-time benefit
25 which may be payable for at least two years, an insurer
26 may at its option insert the following between the
27 first and second sentences of the above provision:

28 Subject to the qualifications set forth below, if
29 the insured suffers loss of time on account of
30 disability for which indemnity may be payable for at
31 least two years, he shall, at least once in
32 every (insert a number not less than one
33 nor more than six) months after having given notice of
34 claim, give to the insurer notice of continuance of
35 said disability, except in the event of legal
36 incapacity. The period of (insert a
37 number not less than one nor more than six) months
38 following any filing of proof by the insured or any
39 payment by the insurer on account of such claim or any
40 denial of liability in whole or in part by the insurer
41 shall be excluded in applying this provision. Delay in
42 the giving of such notice shall not impair the
43 insured's right to any indemnity which would otherwise
44 have accrued during the period of (insert
45 a number not less than one nor more than six) months
46 preceding the date on which such notice is actually
47 given.)
48 . . .

49 Revised Law

50 Sec. 1201.212. POLICY PROVISION: CLAIM FORMS. (a) Except
51 as provided by Subsection (b), an individual accident and health
52 insurance policy must contain the following provision:

53 "Claim Forms: The insurer, on receipt of a notice of claim,

1 will provide to the claimant the forms usually provided by the
2 insurer for filing proof of loss. If the forms are not provided
3 before the 16th day after the date of the notice, the claimant shall
4 be considered to have complied with the requirements of this policy
5 as to proof of loss on submitting, within the time fixed in the
6 policy for filing proofs of loss, written proof covering the
7 occurrence, the character, and the extent of the loss for which the
8 claim is made."

9 (b) The provision required by this section is not required
10 to be contained in a policy issued by a corporation operating under
11 Chapter 842. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

12 Source Law

13 (A) . . . each such policy . . . shall contain
14 the provisions specified in this subsection . . .
15 provided further that Provisions 6 . . . shall not be
16 required provisions under this Subsection A for
17 companies organized under Chapter 20 of this code, as
18 amended. . . .

19 . . .
20 (6) A provision as follows:

21 Claim Forms: The insurer, upon receipt of a
22 notice of claim, will furnish to the claimant such
23 forms as are usually furnished by it for filing proofs
24 of loss. If such forms are not furnished within
25 fifteen days after the giving of such notice the
26 claimant shall be deemed to have complied with the
27 requirements of this policy as to proof of loss upon
28 submitting, within the time fixed in the policy for
29 filing proofs of loss, written proof covering the
30 occurrence, the character and the extent of the loss
31 for which claim is made.

32 . . .

33 Revised Law

34 Sec. 1201.213. POLICY PROVISION: PROOF OF LOSS. An
35 individual accident and health insurance policy must contain the
36 following provision:

37 "Proof of Loss: For a claim for loss for which this policy
38 provides any periodic payment contingent on continuing loss, a
39 written proof of loss must be provided to the insurer at the
40 insurer's designated office before the 91st day after the
41 termination of the period for which the insurer is liable. For a
42 claim for any other loss, a written proof of loss must be provided
43 to the insurer at the insurer's designated office before the 91st

1 day after the date of the loss. Failure to provide the proof within
2 the required time does not invalidate or reduce any claim if it was
3 not reasonably possible to give proof within the required time. In
4 that case, the proof must be provided as soon as reasonably possible
5 but not later than one year after the time proof is otherwise
6 required, except in the event of a legal incapacity." (V.T.I.C.
7 Art. 3.70-3, Sec. (A) (part).)

8 Source Law

9 (A) . . . each such policy . . . shall contain
10 the provisions specified in this subsection

11 . . .
12 (7) A provision as follows:

13 Proofs of Loss: Written proof of loss must
14 be furnished to the insurer at its said office in case
15 of claim for loss for which this policy provides any
16 periodic payment contingent upon continuing loss
17 within ninety days after the termination of the period
18 for which the insurer is liable and in case of claim
19 for any other loss within ninety days after the date of
20 such loss. Failure to furnish such proof within the
21 time required shall not invalidate nor reduce any
22 claim if it was not reasonably possible to give proof
23 within such time, provided such proof is furnished as
24 soon as reasonably possible; and in no event, except in
25 the absence of legal capacity, later than one year from
26 the time proof is otherwise required.
27 . . .

28 Revised Law

29 Sec. 1201.214. POLICY PROVISION: TIME OF PAYMENT OF
30 CLAIMS. (a) Except as provided by Subsection (c), an individual
31 accident and health insurance policy must contain the following
32 provision:

33 "Time of Payment of Claims: Indemnities payable under this
34 policy for any loss, other than a loss for which this policy
35 provides any periodic payment, will be paid immediately on receipt
36 of due written proof of the loss. Subject to due written proof of
37 loss, all accrued indemnities for a loss for which this policy
38 provides periodic payment will be paid _____ (insert period for
39 payment) and any balance remaining unpaid on termination of
40 liability will be paid immediately on receipt of due written proof
41 of loss."

42 (b) The period for payment to be inserted in the clause
43 required by Subsection (a) may not be less frequent than monthly.

1 (c) The provision required by this section is not required
2 to be contained in a policy issued by a corporation operating under
3 Chapter 842. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

4 Source Law

5 (A) . . . each such policy . . . shall contain
6 the provisions specified in this subsection . . .
7 provided further that Provisions . . . 8, and . . .
8 shall not be required provisions under this Subsection
9 A for companies organized under Chapter 20 of this
10 code, as amended. . . .

11 . . .
12 (8) A provision as follows:

13 Time of Payment of Claims: Indemnities
14 payable under this policy for any loss other than loss
15 for which this policy provides any periodic payment
16 will be paid immediately upon receipt of due written
17 proof of such loss. Subject to due written proof of
18 loss, all accrued indemnities for loss for which this
19 policy provides periodic payment will be paid
20 (insert period for payment which must not
21 be less frequently than monthly) and any balance
22 remaining unpaid upon the termination of liability
23 will be paid immediately upon receipt of due written
24 proof.
25 . . .

26 Revised Law

27 Sec. 1201.215. POLICY PROVISION: PAYMENT OF CLAIMS. (a)
28 Except as provided by Subsection (d), an individual accident and
29 health insurance policy must contain the following provision:

30 "Payment of Claims: Indemnity for loss of life will be
31 payable in accordance with the beneficiary designation and the
32 provisions respecting indemnity payments that may be prescribed in
33 this policy and effective at the time of payment. If such a
34 designation or provision is not then effective, the indemnity will
35 be payable to the insured's estate. Any other accrued indemnities
36 unpaid at the insured's death may, at the option of the insurer, be
37 paid either in accordance with the beneficiary designation or to
38 the insured's estate. All other indemnities will be payable to the
39 insured."

40 (b) An insurer may include with the provision required by
41 Subsection (a) one or both of the following provisions:

42 "If any indemnity of this policy is payable to the insured's
43 estate, or to an insured or beneficiary who is a minor or is
44 otherwise not competent to give a valid release, the insurer may pay

1 the indemnity, up to an amount not exceeding \$_____ (insert
2 amount), to any relative by blood or connection by marriage of the
3 insured or beneficiary who is considered by the insurer to be
4 equitably entitled to the indemnity. Any payment made by the
5 insurer in good faith in accordance with this provision fully
6 discharges the insurer to the extent of the payment."

7 "Subject to any written direction of the insured, in the
8 application or otherwise, all or a portion of any indemnity
9 provided by this policy on account of hospital, nursing, medical,
10 or surgical services may, at the insurer's option and unless the
11 insured requests otherwise in writing not later than the time of
12 filing proof of the loss, be paid directly to the hospital or person
13 providing the services. It is not required that the service be
14 provided by a particular hospital or person."

15 (c) The amount to be inserted in the clause permitted by
16 Subsection (b) may not exceed \$1,000.

17 (d) The provision required by Subsection (a) is not required
18 to be contained in a policy issued by a corporation operating under
19 Chapter 842. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

20 Source Law

21 (A) . . . each such policy . . . shall contain
22 the provisions specified in this subsection . . .
23 provided further that Provisions . . . 9 shall not be
24 required provisions under this Subsection A for
25 companies organized under Chapter 20 of this code, as
26 amended. . . .

27 . . .
28 (9) A provision as follows:
29 Payment of Claims: Indemnity for loss of
30 life will be payable in accordance with the
31 beneficiary designation and the provisions respecting
32 such payment which may be prescribed herein and
33 effective at the time of payment. If no such
34 designation or provision is then effective, such
35 indemnity shall be payable to the estate of the
36 insured. Any other accrued indemnities unpaid at the
37 insured's death may, at the option of the insurer, be
38 paid either to such beneficiary or to such estate. All
39 other indemnities will be payable to the insured.

40 (The following provisions, or either of
41 them, may be included with the foregoing provision at
42 the option of the insurer:

43 If any indemnity of this policy shall be payable
44 to the estate of the insured, or to an insured or
45 beneficiary who is a minor or otherwise not competent
46 to give a valid release, the insurer may pay such
47 indemnity, up to an amount not exceeding \$

1 (insert an amount which shall not exceed \$1,000), to
2 any relative by blood or connection by marriage of the
3 insured or beneficiary who is deemed by the insurer to
4 be equitably entitled thereto. Any payment made by the
5 insurer in good faith pursuant to this provision shall
6 fully discharge the insurer to the extent of such
7 payment.

8 Subject to any written direction of the insured
9 in the application or otherwise all or a portion of any
10 indemnities provided by this policy on account of
11 hospital, nursing, medical or surgical services may,
12 at the insurer's option and unless the insured requests
13 otherwise in writing not later than the time of filing
14 proofs of such loss, be paid directly to the hospital
15 or person rendering such services; but it is not
16 required that the service be rendered by a particular
17 hospital or person.)
18 . . .

19 Revised Law

20 Sec. 1201.216. POLICY PROVISION: PHYSICAL EXAMINATIONS AND
21 AUTOPSY. An individual accident and health insurance policy must
22 contain the following provision:

23 "Physical Examinations and Autopsy: The insurer at its own
24 expense has the right and opportunity to conduct a physical
25 examination of the insured when and as often as the insurer
26 reasonably requires while a claim under the policy is pending and,
27 in case of death, to require that an autopsy be conducted if not
28 forbidden by law." (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

29 Source Law

30 (A) . . . each such policy . . . shall contain
31 the provisions specified in this subsection

32 . . .

33 (10) A provision as follows:

34 Physical Examinations and Autopsy: The
35 insurer at its own expense shall have the right and
36 opportunity to examine the person of the insured when
37 and as often as it may reasonably require during the
38 pendency of a claim hereunder and to make an autopsy in
39 case of death where it is not forbidden by law.
40 . . .

41 Revised Law

42 Sec. 1201.217. POLICY PROVISION: LEGAL ACTIONS. An
43 individual accident and health insurance policy must contain the
44 following provision:

45 "Legal Actions: An action at law or in equity may not be
46 brought to recover on this policy before the 61st day after the date
47 written proof of loss has been provided in accordance with the
48 requirements of this policy. An action at law or in equity may not

1 be brought after the expiration of three years after the time
2 written proof of loss is required to be provided." (V.T.I.C. Art.
3 3.70-3, Sec. (A) (part).)

4 Source Law

5 (A) . . . each such policy . . . shall contain
6 the provisions specified in this subsection

7

8 (11) A provision as follows:

9 Legal Actions: No action at law or in
10 equity shall be brought to recover on this policy prior
11 to the expiration of sixty days after written proof of
12 loss has been furnished in accordance with the
13 requirements of this policy. No such action shall be
14 brought after the expiration of three years after the
15 time written proof of loss is required to be furnished.
16

17 Revised Law

18 Sec. 1201.218. POLICY PROVISION: CHANGE OF BENEFICIARY.

19 (a) Except as provided by Subsection (b), an individual accident
20 and health insurance policy must contain the following provision:

21 "Change of Beneficiary: Unless the insured makes an
22 irrevocable designation of beneficiary, the right to change a
23 beneficiary is reserved for the insured, and the consent of the
24 beneficiary or beneficiaries is not required for the surrender or
25 assignment of this policy, for any change of beneficiary or
26 beneficiaries, or for any other changes in this policy."

27 (b) An insurer may omit the first clause of the provision
28 required by Subsection (a) relating to an irrevocable designation
29 of beneficiary. (V.T.I.C. Art. 3.70-3, Sec. (A) (part).)

30 Source Law

31 (A) . . . each such policy . . . shall contain
32 the provisions specified in this subsection

33

34 (12) A provision as follows:

35 Change of Beneficiary: Unless the insured
36 makes an irrevocable designation of beneficiary, the
37 right to change of beneficiary is reserved to the
38 insured and the consent of the beneficiary or
39 beneficiaries shall not be requisite to surrender or
40 assignment of this policy or to any change of
41 beneficiary or beneficiaries, or to any other changes
42 in this policy.

43 (The first clause of this provision,
44 relating to the irrevocable designation of
45 beneficiary, may be omitted at the insurer's option.)

1 Revised Law

2 Sec. 1201.219. POLICY PROVISION: CHANGE OF OCCUPATION. An
3 individual accident and health insurance policy must contain the
4 following provision if the policy addresses the subject matter of
5 the provision:

6 "Change of Occupation: If the insured is injured or
7 contracts a sickness after the insured changes the insured's
8 occupation to one classified by the insurer as more hazardous than
9 the occupation stated in this policy or while doing for
10 compensation anything pertaining to an occupation so classified,
11 the insurer will pay only the portion of the indemnity provided in
12 this policy as the premium paid would have purchased at the rates
13 and within the limits fixed by the insurer for the more hazardous
14 occupation. If the insured changes the insured's occupation to one
15 classified by the insurer as less hazardous than the occupation
16 stated in this policy, the insurer, on receipt of proof of the
17 change of occupation, will reduce the premium rate accordingly, and
18 will return the excess pro rata unearned premium from the date of
19 change of occupation or from the policy anniversary date
20 immediately preceding the receipt of the proof, whichever date is
21 more recent. In applying this provision, the classification of
22 occupational risk and the premium rates are the classification and
23 rates that, before the occurrence of the loss for which the insurer
24 is liable or before the date of proof of change in occupation, were:

25 (1) last filed by the insurer with the state official
26 having supervision of insurance in the state where the insured
27 resided at the time this policy was issued; or

28 (2) if filing was not required, last made effective by
29 the insurer in the state where the insured resided at the time this
30 policy was issued." (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

31 Source Law

32 (B) . . . no such policy . . . shall contain
33 provisions respecting the matters set forth below
34 unless such provisions are in the words in which the
35 same appear in this section

36 (1) A provision as follows:

1 Change of Occupation: If the insured be
2 injured or contract sickness after having changed his
3 occupation to one classified by the insurer as more
4 hazardous than that stated in this policy or while
5 doing for compensation anything pertaining to an
6 occupation so classified, the insurer will pay only
7 such portion of the indemnities provided in this
8 policy as the premium paid would have purchased at the
9 rates and within the limits fixed by the insurer for
10 such more hazardous occupation. If the insured
11 changes his occupation to one classified by the
12 insurer as less hazardous than that stated in this
13 policy, the insurer, upon receipt of proof of such
14 change of occupation, will reduce the premium rate
15 accordingly, and will return the excess pro-rata
16 unearned premium from the date of change of occupation
17 or from the policy anniversary date immediately
18 preceding receipt of such proof, whichever is the more
19 recent. In applying this provision, the
20 classification of occupational risk and the premium
21 rates shall be such as have been last filed by the
22 insurer prior to the occurrence of the loss for which
23 the insurer is liable or prior to date of proof of
24 change in occupation with the state official having
25 supervision of insurance in the state where the
26 insured resided at the time this policy was issued; but
27 if such filing was not required, then the
28 classification of occupational risk and the premium
29 rates shall be those last made effective by the insurer
30 in such state prior to the occurrence of the loss or
31 prior to the date of proof of change in occupation.
32 . . .

33 Revised Law

34 Sec. 1201.220. POLICY PROVISION: MISSTATEMENT OF AGE. An
35 individual accident and health insurance policy must contain the
36 following provision if the policy addresses the subject matter of
37 the provision:

38 "Misstatement of Age: If the age of the insured has been
39 misstated, the amounts payable under this policy are the amounts
40 the premium paid would have purchased at the correct age."

41 (V.T.I.C. Art. 3.70-3, Sec. (B) (part).)

42 Source Law

43 (B) . . . no such policy . . . shall contain
44 provisions respecting the matters set forth below
45 unless such provisions are in the words in which the
46 same appear in this section

47 . . .
48 (2) A provision as follows:

49 Misstatement of Age: If the age of the
50 insured has been misstated, all amounts payable under
51 this policy shall be such as the premium paid would
52 have purchased at the correct age.
53 . . .

54 Revised Law

55 Sec. 1201.221. POLICY PROVISION: EXCESS INSURANCE. An

1 individual accident and health insurance policy must contain one of
2 the following provisions if the policy addresses the subject matter
3 of the provision:

4 "Other Insurance With This Insurer: If an accident or health
5 or accident and health policy or policies previously issued by the
6 insurer to the insured is in force concurrently with this policy,
7 making the aggregate indemnity for _____ (insert types of
8 coverages) in excess of \$_____ (insert maximum limit of indemnity
9 or indemnities), the excess insurance is void and all premiums paid
10 for the excess shall be returned to the insured or to the insured's
11 estate."

12 "Other Insurance With This Insurer: Insurance effective at
13 any one time on the insured under the same type of policy or
14 policies with this insurer is limited to the one policy elected by
15 the insured, the insured's beneficiary, or the insured's estate, as
16 the case may be, and the insurer will return all premiums paid for
17 all other policies of the same type." (V.T.I.C. Art. 3.70-3, Sec.
18 (B) (part).)

19 Source Law

20 (B) . . . no such policy . . . shall contain
21 provisions respecting the matters set forth below
22 unless such provisions are in the words in which the
23 same appear in this section

24
25 (3) A provision as follows:
26 Other Insurance in This Insurer: If an
27 accident or sickness or accident and sickness policy
28 or policies previously issued by the insurer to the
29 insured be in force concurrently herewith, making the
30 aggregate indemnity for (insert type of
31 coverage or coverages) in excess of
32 \$ (insert maximum limit of indemnity or
33 indemnities) the excess insurance shall be void and
34 all premiums paid for such excess shall be returned to
35 the insured or to his estate;
36 or, in lieu thereof:
37 Insurance effective at any one time on the
38 insured under a like policy or policies in this insurer
39 is limited to the one such policy elected by the
40 insured, his beneficiary or his estate, as the case may
41 be, and the insurer will return all premiums paid for
42 all other such policies.
43 . . .

44 Revised Law

45 Sec. 1201.222. POLICY PROVISION: RELATION OF EARNINGS TO

1 INSURANCE. (a) Subject to Subsection (b), an individual accident
2 and health insurance policy must contain the following provision if
3 the policy addresses the subject matter of the provision:

4 "Relation of Earnings to Insurance: If the total monthly
5 amount of loss of time benefits promised for the same loss under all
6 valid loss of time coverage on the insured, regardless of whether
7 the benefits are payable on a weekly or monthly basis, exceeds the
8 amount of monthly earnings of the insured at the time the insured's
9 disability began or the insured's average amount of monthly
10 earnings for the period of two years immediately preceding a
11 disability for which claim is made, whichever amount is greater,
12 the insurer will be liable only for the proportionate amount of loss
13 of time benefits under this policy as the amount of the insured's
14 monthly earnings or average monthly earnings bears to the total
15 amount of monthly benefits for the same loss under all loss of time
16 coverage on the insured at the time the disability begins and for
17 the return of the part of the premiums paid during the immediately
18 preceding two years that exceeds the pro rata amount of the premiums
19 for the benefits actually paid under this policy. This provision
20 does not reduce the total monthly amount of benefits payable under
21 all loss of time coverage on the insured to less than \$200 or the sum
22 of the monthly benefits specified in the loss of time coverages,
23 whichever amount is less, and does not reduce benefits other than
24 loss of time benefits."

25 (b) The provision described by Subsection (a) may be
26 included only in a policy that provides that the insured is entitled
27 to continue the policy in force subject to its terms by the timely
28 payment of premiums until the insured reaches at least 50 years of
29 age or, if the policy was issued after the insured reached 44 years
30 of age, until at least the fifth anniversary of the policy's date of
31 issuance.

32 (c) An insurer may include in the provision described by
33 Subsection (a) a definition of "valid loss of time coverage." The
34 form of the definition must be approved by the commissioner. The

1 subject matter of the definition must be limited to:

2 (1) coverage provided by:

3 (A) governmental agencies; or

4 (B) organizations subject to regulation by
5 insurance laws or by insurance authorities of this or any other
6 state or any province of Canada;

7 (2) any other coverage the inclusion of which is
8 approved by the commissioner; or

9 (3) any combination of coverages described by
10 Subdivisions (1) and (2).

11 (d) In the absence of a definition authorized under
12 Subsection (c), "valid loss of time coverage" does not include:

13 (1) coverage provided for the insured under a
14 compulsory benefit statute, including a workers' compensation or
15 employer's liability statute; or

16 (2) benefits provided by:

17 (A) a union welfare plan;

18 (B) an employer benefit organization; or

19 (C) an employee benefit organization. (V.T.I.C.

20 Art. 3.70-3, Sec. (B) (part).)

21 Source Law

22 (B) . . . no such policy . . . shall contain
23 provisions respecting the matters set forth below
24 unless such provisions are in the words in which the
25 same appear in this section

26
27 (4) A provision as follows:

28 Relation of Earnings to Insurance: If the
29 total monthly amount of loss of time benefits promised
30 for the same loss under all valid loss of time coverage
31 upon the insured, whether payable on a weekly or
32 monthly basis, shall exceed the monthly earnings of
33 the insured at the time disability commenced or his
34 average monthly earnings for the period of two years
35 immediately preceding a disability for which claim is
36 made, whichever is the greater, the insurer will be
37 liable only for such proportionate amount of such
38 benefits under this policy as the amount of such
39 monthly earnings or such average monthly earnings of
40 the insured bears to the total amount of monthly
41 benefits for the same loss under all such coverage upon
42 the insured at the time such disability commences and
43 for the return of such part of the premiums paid during
44 such two years as shall exceed the pro-rata amount of
45 the premiums for the benefits actually paid hereunder;
46 but this shall not operate to reduce the total monthly

1 amount of benefits payable under all such coverage
2 upon the insured below the sum of Two Hundred Dollars
3 (\$200.00) or the sum of the monthly benefits specified
4 in such coverages, whichever is the lesser, nor shall
5 it operate to reduce benefits other than those payable
6 for loss of time.

7 (The foregoing policy provision may be
8 inserted only in a policy which the insured has the
9 right to continue in force subject to its terms by the
10 timely payment of premiums (1) until at least age 50
11 or, (2) in the case of a policy issued after age 44, for
12 at least five years from its date of issue. The
13 insurer may, at its option, include in this provision a
14 definition of "valid loss of time coverage," approved
15 as to form by the Board, which definition shall be
16 limited in subject matter to coverage provided by
17 governmental agencies or by organizations subject to
18 regulation by insurance law or by insurance
19 authorities of this or any other state of the United
20 States or any province of Canada, or to any other
21 coverage the inclusion of which may be approved by the
22 Board or any combination of such coverages. In the
23 absence of such definition such term shall not include
24 any coverage provided for such insured pursuant to any
25 compulsory benefit statute (including any workmen's
26 compensation or employer's liability statute), or
27 benefits provided by union welfare plans or by
28 employer or employee benefit organizations.)
29 . . .

30 Revised Law

31 Sec. 1201.223. POLICY PROVISION: UNPAID PREMIUM. An
32 individual accident and health insurance policy must contain the
33 following provision if the policy addresses the subject matter of
34 the provision:

35 "Unpaid Premium: At the time of payment of a claim under this
36 policy, any premium then due and unpaid or covered by any note or
37 written order may be deducted from the payment." (V.T.I.C. Art.
38 3.70-3, Sec. (B) (part).)

39 Source Law

40 (B) . . . no such policy . . . shall contain
41 provisions respecting the matters set forth below
42 unless such provisions are in the words in which the
43 same appear in this section

44 . . .
45 (5) A provision as follows:

46 Unpaid Premium: Upon the payment of a claim
47 under this policy, any premium then due and unpaid or
48 covered by any note or written order may be deducted
49 therefrom.
50 . . .

51 Revised Law

52 Sec. 1201.224. POLICY PROVISION: CANCELLATION. An
53 individual accident and health insurance policy must contain the

1 following provision if the policy addresses the subject matter of
2 the provision:

3 "Cancellation: The insurer may cancel this policy at any
4 time by written notice delivered to the insured, or mailed to the
5 insured's last address as shown by the records of the insurer,
6 stating when the cancellation is effective, which may not be
7 earlier than five days after the date the notice is delivered or
8 mailed. After this policy has been continued beyond its original
9 term, the insured may cancel the policy at any time by written
10 notice delivered or mailed to the insurer, effective on receipt or
11 on a later date specified in the notice. In the event of
12 cancellation, the insurer will promptly return the unearned portion
13 of any premium paid. If the insured cancels, the earned premium
14 shall be computed by the use of the short-rate table last filed with
15 the state official having supervision of insurance in the state
16 where the insured resided when the policy was issued. If the
17 insurer cancels, the earned premium shall be computed pro rata.
18 Cancellation is without prejudice to any claim originating before
19 the effective date of cancellation." (V.T.I.C. Art. 3.70-3, Sec.
20 (B) (part).)

21 Source Law

22 (B) . . . no such policy . . . shall contain
23 provisions respecting the matters set forth below
24 unless such provisions are in the words in which the
25 same appear in this section

26 . . .
27 (6) A provision as follows:

28 Cancellation: The insurer may cancel this
29 policy at any time by written notice delivered to the
30 insured, or mailed to his last address as shown by the
31 records of the insurer, stating when, not less than
32 five days thereafter, such cancellation shall be
33 effective; and after the policy has been continued
34 beyond its original term the insured may cancel this
35 policy at any time by written notice delivered or
36 mailed to the insurer, effective upon receipt or on
37 such later date as may be specified in such notice. In
38 the event of cancellation, the insurer will return
39 promptly the unearned portion of any premium paid. If
40 the insured cancels, the earned premium shall be
41 computed by the use of the short-rate table last filed
42 with the state official having supervision of
43 insurance in the state where the insured resided when
44 the policy was issued. If the insurer cancels, the
45 earned premium shall be computed pro-rata.
46 Cancellation shall be without prejudice to any claim

1 originating prior to the effective date of
2 cancellation.
3 . . .

4 Revised Law

5 Sec. 1201.225. POLICY PROVISION: CONFORMITY WITH STATE
6 STATUTES. An individual accident and health insurance policy must
7 contain the following provision if the policy addresses the subject
8 matter of the provision:

9 "Conformity With State Statutes: Any provision of this
10 policy that, on its effective date, conflicts with the statutes of
11 the state in which the insured resides on the effective date is by
12 this clause effectively amended to conform to the minimum
13 requirements of that state's statutes." (V.T.I.C. Art. 3.70-3,
14 Sec. (B) (part).)

15 Source Law

16 (B) . . . no such policy . . . shall contain
17 provisions respecting the matters set forth below
18 unless such provisions are in the words in which the
19 same appear in this section

20 . . .
21 (7) A provision as follows:

22 Conformity With State Statutes: Any
23 provision of this policy which, on its effective date,
24 is in conflict with the statutes of the state in which
25 the insured resides on such date is hereby amended to
26 conform to the minimum requirements of such statutes.
27 . . .

28 Revised Law

29 Sec. 1201.226. POLICY PROVISION: ILLEGAL OCCUPATION. An
30 individual accident and health insurance policy must contain the
31 following provision if the policy addresses the subject matter of
32 the provision:

33 "Illegal Occupation: The insurer is not liable for any loss
34 to which a contributing cause was the insured's commission of or
35 attempt to commit a felony or to which a contributing cause was the
36 insured's being engaged in an illegal occupation." (V.T.I.C. Art.
37 3.70-3, Sec. (B) (part).)

38 Source Law

39 (B) . . . no such policy . . . shall contain
40 provisions respecting the matters set forth below
41 unless such provisions are in the words in which the
42 same appear in this section
43 . . .

1 (8) A provision as follows:
2 Illegal Occupation: The insurer shall not
3 be liable for any loss to which a contributing cause
4 was the insured's commission of or attempt to commit a
5 felony or to which a contributing cause was the
6 insured's being engaged in an illegal occupation.
7 . . .

8 Revised Law

9 Sec. 1201.227. POLICY PROVISION: INTOXICANTS AND
10 NARCOTICS. An individual accident and health insurance policy
11 must contain the following provision if the policy addresses the
12 subject matter of the provision:

13 "Intoxicants and Narcotics: The insurer is not liable for
14 any loss sustained or contracted in consequence of the insured's
15 being intoxicated or under the influence of any narcotic unless the
16 narcotic is administered on the advice of a physician." (V.T.I.C.
17 Art. 3.70-3, Sec. (B) (part).)

18 Source Law

19 (B) . . . no such policy . . . shall contain
20 provisions respecting the matters set forth below
21 unless such provisions are in the words in which the
22 same appear in this section
23 . . .

24 (9) A provision as follows:
25 Intoxicants and Narcotics: The insurer
26 shall not be liable for any loss sustained or
27 contracted in consequence of the insured's being
28 intoxicated or under the influence of any narcotic
29 unless administered on the advice of a physician.

30 [Sections 1201.228-1201.270 reserved for expansion]

31 SUBCHAPTER F. APPLICATION FOR POLICY

32 Revised Law

33 Sec. 1201.271. ALTERATION OF POLICY APPLICATION. (a) A
34 person may not alter a written application for an individual
35 accident and health insurance policy unless the person has the
36 written consent of the applicant.

37 (b) Notwithstanding Subsection (a), an insurer may make an
38 insertion to an application solely for administrative purposes in a
39 manner that indicates clearly that the insertion is not attributed
40 to the applicant. (V.T.I.C. Art. 3.70-5, Sec. (B).)

41 Source Law

42 (B) No alteration of any written application for
43 any such policy shall be made by any person other than

1 the applicant without his written consent, except that
2 insertions may be made by the insurer, for
3 administrative purposes only, in such manner as to
4 indicate clearly that such insertions are not to be
5 ascribed to the applicant.

6 Revised Law

7 Sec. 1201.272. FALSE STATEMENTS. The falsity of a
8 statement in an application for an individual accident and health
9 insurance policy does not bar a right to recovery under the policy
10 unless the statement materially affected the acceptance of the risk
11 or the hazard assumed by the insurer. (V.T.I.C. Art. 3.70-5, Sec.
12 (C).)

13 Source Law

14 (C) The falsity of any statement in the
15 application for any policy covered by this Act may not
16 bar the right to recovery thereunder unless such false
17 statement materially affected either the acceptance of
18 the risk or the hazard assumed by the insurer.

19 Revised Law

20 Sec. 1201.273. BINDING STATEMENTS. An insured may not be
21 bound by a statement made in an application for an individual
22 accident and health insurance policy unless a copy of the
23 application is attached to or endorsed on the policy as a part of
24 the policy when issued. (V.T.I.C. Art. 3.70-5, Sec. (A) (part).)

25 Source Law

26 Art. 3.70-5. (A) The insured shall not be bound
27 by any statement made in an application for a policy
28 unless a copy of such application is attached to or
29 endorsed on the policy when issued as a part
30 thereof. . . .

31 Revised Law

32 Sec. 1201.274. INSURER'S EVIDENTIARY USE OF APPLICATION FOR
33 REINSTATEMENT OR RENEWAL. (a) If an individual accident and health
34 insurance policy is reinstated or renewed, and the insured or the
35 beneficiary or assignee of the policy makes a written request for a
36 copy of the application for reinstatement or renewal, the insurer
37 shall, not later than the 15th day after the date the insurer
38 receives the request at its home or branch office, deliver or mail a
39 copy of the application to the person who made the request.

40 (b) An insurer that fails to comply with this section may

1 not introduce the application for reinstatement or renewal as
2 evidence in any action or proceeding based on or involving the
3 policy or its reinstatement or renewal. (V.T.I.C. Art. 3.70-5,
4 Sec. (A) (part).)

5 Source Law

6 (A) If any such policy delivered or
7 issued for delivery to any person in this state shall
8 be reinstated or renewed, and the insured or the
9 beneficiary or assignee of such policy shall make
10 written request to the insurer for a copy of the
11 application, if any, for such reinstatement or
12 renewal, the insurer shall within fifteen days after
13 the receipt of such request at its home office or any
14 branch office of the insurer, deliver or mail to the
15 person making such request, a copy of such
16 application. If such copy shall not be so delivered or
17 mailed, the insurer shall be precluded from
18 introducing such application as evidence in any action
19 or proceeding based upon or involving such policy or
20 its reinstatement or renewal.

21 [Sections 1201.275-1201.700 reserved for expansion]

22 SUBCHAPTER O. ENFORCEMENT

23 Revised Law

24 Sec. 1201.701. CIVIL PENALTY. A person, partnership, or
25 corporation that wilfully violates this chapter or an order of the
26 commissioner made under this chapter is liable to the state for a
27 civil penalty in an amount not to exceed \$5,000 for each violation.
28 The penalty may be recovered through a civil action. (V.T.I.C. Art.
29 3.70-9 (part).)

30 Source Law

31 Art. 3.70-9. Any person, partnership, or
32 corporation wilfully violating any provision of this
33 Act or order of the Board made in accordance with this
34 Act, shall forfeit to the people of the state a sum not
35 to exceed Five Thousand Dollars (\$5,000.00) for each
36 such violation, which may be recovered by a civil
37 action. . . .

38 Revised Law

39 Sec. 1201.702. ACTION AGAINST CERTIFICATE OF AUTHORITY OR
40 LICENSE. The commissioner may suspend or revoke the certificate of
41 authority or license of an insurer or agent who wilfully violates
42 this chapter or an order of the commissioner made under this
43 chapter. (V.T.I.C. Art. 3.70-9 (part).)

1 Source Law

2 Art. 3.70-9. . . . The Board may also suspend
3 or revoke the license of an insurer or agent for any
4 such wilful violation.

5 Revisor's Note

6 V.T.I.C. Article 3.70-9 refers to a "license of
7 an insurer or agent." The revised law adds a reference
8 to a "certificate of authority" of an insurer for
9 consistency with terminology used throughout this
10 code.

11 Revisor's Note
12 (End of Chapter)

13 The revised law omits V.T.I.C. Article 3.70-11 as
14 executed. That article provided for a five-year
15 period after the effective date of the act containing
16 the article (Chapter 397, Acts of the 54th
17 Legislature, Regular Session, 1955) during which
18 certain other provisions in the act were inapplicable
19 to previously authorized policies, riders, or
20 endorsements. Chapter 397 took effect in 1955, and the
21 five-year period has expired. The omitted law reads:

22 Art. 3.70-11. A policy, rider or
23 endorsement, which could have been lawfully
24 used or delivered or issued for delivery to
25 any person in this state immediately before
26 the effective date of this Act may be used
27 or delivered or issued for delivery to any
28 such person during five years after the
29 effective date of this Act without being
30 subject to the provisions of Sections 2, 3,
31 or 4 of this Act.

32 CHAPTER 1202. CANCELLATION AND CONTINUATION OF POLICIES
33 IN GENERAL

34 SUBCHAPTER A. CONTINUOUS POLICIES

35 Sec. 1202.001. CONTINUOUS POLICIES 632
36 [Sections 1202.002-1202.050 reserved for expansion]

37 SUBCHAPTER B. INDIVIDUAL HEALTH INSURANCE POLICIES

38 Sec. 1202.051. RENEWABILITY AND CONTINUATION OF INDIVIDUAL
39 HEALTH INSURANCE POLICIES 633
40 Sec. 1202.052. CANCELLATION PROHIBITED FOR AIDS OR HIV . . . 634

1 CHAPTER 1202. CANCELLATION AND CONTINUATION OF POLICIES

2 IN GENERAL

3 SUBCHAPTER A. CONTINUOUS POLICIES

4 Revised Law

5 Sec. 1202.001. CONTINUOUS POLICIES. (a) A guaranteed
6 renewable insurance policy or a noncancellable insurance policy is
7 considered to be a continuous policy, subject only to the policy
8 terms and conditions, including payment of the policy premium.

9 (b) A guaranteed renewable insurance policy or a
10 noncancellable insurance policy:

11 (1) is continued in effect by the payment of the policy
12 premium in accordance with the policy terms and conditions; and

13 (2) may not be considered or treated as a renewed
14 policy by the payment of the policy premium.

15 (c) This section does not apply to a small employer health
16 benefit plan adopted in accordance with Chapter 1501. (V.T.I.C.
17 Art. 3.70-13.)

18 Source Law

19 Art. 3.70-13. A guaranteed renewable policy or
20 a noncancellable policy shall be deemed to be a
21 continuous policy, subject only to the terms and
22 conditions thereof, including payment of policy
23 premiums, and such policies shall be considered to be
24 continued in force by the payment of the policy premium
25 in accordance with the policy terms and conditions,
26 and such policies shall not be deemed or treated as
27 renewed policies by the payment of such contracted
28 policy premiums. This article does not apply to a
29 health benefit plan adopted in accordance with Chapter
30 26 of this code, as added by H.B. No. 2055, Acts of the
31 73rd Legislature, Regular Session, 1993.

32 Revisor's Note

33 V.T.I.C. Article 3.70-13, in the second sentence,
34 refers to a "health benefit plan adopted in accordance
35 with Chapter 26 of this code, as added by H.B. No.
36 2055, Acts of the 73rd Legislature, Regular Session,
37 1993." When enacted by that bill, Chapter 26 addressed
38 only benefit plans offered by small employers.
39 Provisions addressing benefit plans offered by large
40 employers were later added to Chapter 26 through

1 enactment of H.B. No. 1212, Acts of the 75th
2 Legislature, Regular Session, 1997. Consequently, the
3 revised law refers to a "small employer health benefit
4 plan" for clarity and to reflect legislative intent.

5 [Sections 1202.002-1202.050 reserved for expansion]

6 SUBCHAPTER B. INDIVIDUAL HEALTH INSURANCE POLICIES

7 Revised Law

8 Sec. 1202.051. RENEWABILITY AND CONTINUATION OF INDIVIDUAL
9 HEALTH INSURANCE POLICIES. (a) This section applies only to an
10 individual health insurance policy that provides benefits for
11 medical care under a hospital, medical, or surgical policy.

12 (b) Except as provided by Subsection (c), an insurer shall
13 renew or continue an individual health insurance policy at the
14 option of the individual.

15 (c) An insurer may decline to renew or continue an
16 individual health insurance policy:

17 (1) for failure to pay a premium or contribution in
18 accordance with the terms of the policy;

19 (2) for fraud or intentional misrepresentation;

20 (3) because the insurer is ceasing to offer coverage
21 in the individual market in accordance with rules adopted by the
22 commissioner;

23 (4) because an individual no longer resides, lives, or
24 works in an area in which the insurer is authorized to provide
25 coverage, but only if all policies are not renewed or not continued
26 under this subdivision uniformly without regard to any
27 health-status related factor of covered individuals; or

28 (5) in accordance with federal law, including
29 regulations.

30 (d) The commissioner shall adopt rules necessary to:

31 (1) implement this section; and

32 (2) meet the minimum requirements of federal law,
33 including regulations. (V.T.I.C. Art. 3.70-1A.)

1 Source Law

2 Art. 3.70-1A. (a) Except as otherwise provided
3 in this article, an individual health insurance policy
4 providing benefits for medical care under a hospital,
5 medical, or surgical policy shall be renewed or
6 continued in force at the option of the individual.

7 (b) An individual health insurance policy
8 providing benefits for medical care under a hospital,
9 medical, or surgical policy may be nonrenewed or
10 discontinued based only on one or more of the following
11 reasons:

12 (1) failure to pay premiums or
13 contributions in accordance with the terms of the
14 policy;

15 (2) fraud or intentional
16 misrepresentation;

17 (3) the insurance company is ceasing to
18 offer coverage in the individual market in accordance
19 with rules established by the commissioner;

20 (4) an individual no longer resides,
21 lives, or works in an area in which the insurer is
22 authorized to provide coverage, but only if such
23 coverage is terminated under this subdivision
24 uniformly without regard to any health-status related
25 factor of covered individuals; or

26 (5) in accordance with applicable federal
27 law and regulations.

28 (c) The commissioner shall adopt rules
29 necessary to implement this article and to meet the
30 minimum requirements of federal law and regulations.

31 Revised Law

32 Sec. 1202.052. CANCELLATION PROHIBITED FOR AIDS OR
33 HIV. (a) In this section, "AIDS" and "HIV" have the meanings
34 assigned by Section 81.101, Health and Safety Code.

35 (b) Except as provided by Subsection (c), an insurer that
36 delivers or issues for delivery an individual accident and health
37 insurance policy in this state may not cancel that policy during its
38 term because the insured:

39 (1) has been diagnosed as having AIDS or HIV;

40 (2) has been treated for AIDS or HIV; or

41 (3) is being treated for AIDS or HIV.

42 (c) The insurer may cancel the policy for:

43 (1) failure to pay a premium when due; or

44 (2) fraud or misrepresentation in obtaining coverage
45 by not disclosing a diagnosis of an AIDS or HIV-related condition.

46 (d) The provisions of Chapter 1201, including provisions
47 relating to the applicability, purpose, and enforcement of that
48 chapter, construction of policies under that chapter, rulemaking

1 under that chapter, and definitions of terms applicable in that
2 chapter, apply to this section. (V.T.I.C. Art. 3.70-3A; New.)

3 Source Law

4 Art. 3.70-3A. (a) Except as provided by
5 Subsection (b) of this section, an insurer that
6 delivers or issues for delivery an accident and
7 sickness insurance policy in this state may not cancel
8 that policy during its term because the insured has
9 been diagnosed as having or has been or is being
10 treated for HIV or AIDS as defined by Section 81.101,
11 Health and Safety Code.

12 (b) An insurer may cancel an insurance policy
13 covered by Subsection (a) of this section for fraud or
14 misrepresentation in obtaining coverage by not
15 disclosing a diagnosis of AIDS or HIV-related
16 conditions or for failure to pay premiums when due.

17 Revisor's Note

18 (1) Section (a), V.T.I.C. Article 3.70-3A,
19 refers to an "accident and sickness insurance policy."
20 The revised law substitutes "individual accident and
21 health insurance policy" for the quoted language. The
22 revised law adds "individual" for clarity because it
23 is clear from the placement of Article 3.70-3A in
24 Subchapter G, Chapter 3, Insurance Code, that the
25 article is intended to address individual policies
26 only. Section (C), V.T.I.C. Article 3.70-1, states
27 that Subchapter G applies only to "individual accident
28 and sickness insurance policies." The revised law
29 substitutes "health" for "sickness" for consistency
30 with modern usage.

31 (2) Chapter 397, Acts of the 54th Legislature,
32 Regular Session, 1955, published as V.T.I.C. Articles
33 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4,
34 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and
35 3.70-11, contains general provisions applicable to
36 V.T.I.C. Article 3.70-3A, revised as this section.
37 The majority of these articles are revised in this code
38 as Chapter 1201. Section 1202.052(d) is added to
39 indicate the applicability of those general provisions
40 to this section. For the convenience of the reader,

1 the revised law includes general descriptions of some
2 of the applicable provisions of Chapter 1201.

3 CHAPTER 1203. COORDINATION OF BENEFITS PROVISIONS

4 Sec. 1203.001. APPLICABILITY OF CHAPTER 636

5 Sec. 1203.002. CERTAIN COORDINATION OF BENEFITS PROVISIONS
6 PROHIBITED 637

7 Sec. 1203.003. CERTAIN COORDINATION OF BENEFITS PROVISIONS
8 VOID 638

9 CHAPTER 1203. COORDINATION OF BENEFITS PROVISIONS

10 Revised Law

11 Sec. 1203.001. APPLICABILITY OF CHAPTER. (a) This
12 chapter applies only to:

13 (1) a policy of group accident and health insurance as
14 described by Chapter 1251;

15 (2) a policy of blanket accident and health insurance
16 as described by Chapter 1251;

17 (3) a policy of individual accident and health
18 insurance as defined by Section 1201.001; or

19 (4) an evidence of coverage as defined by Section
20 843.002.

21 (b) This chapter does not apply to an individual accident
22 and health insurance policy that is designed to fully integrate
23 with other policies through a variable deductible. (V.T.I.C. Art.
24 3.51-6B, Sec. 1(a) (part).)

25 Source Law

26 Art. 3.51-6B

27 Sec. 1. (a) A policy of group accident and
28 health insurance or blanket accident and health
29 insurance as defined by Sections 1 and 2, Article
30 3.51-6, Insurance Code, an individual policy of
31 accident and sickness insurance as defined by Section
32 1(B)(3), Chapter 397, Acts of the 54th Legislature,
33 Regular Session, 1955 (Article 3.70-1, Vernon's Texas
34 Insurance Code), except an individual policy designed
35 to fully integrate with other policies through a
36 variable deductible, or an evidence of coverage as
37 defined by the Texas Health Maintenance Organization
38 Act (Chapter 20A, Vernon's Texas Insurance Code), [may
39 not be delivered, issued for delivery, or renewed in
40 this state if the terms of the policy or evidence of
41 coverage exclude or reduce the payment of benefits to
42 or on behalf of an insured or enrollee because benefits

1 are also payable or have been paid under a supplemental
2 policy of accident and health insurance that is
3 individually underwritten and individually issued as a
4 hospital confinement indemnity, specified disease or
5 limited benefit plan of coverage.]

6 Revisor's Note

7 Section 1(a), V.T.I.C. Article 3.51-6B, refers to
8 "an individual policy of accident and sickness
9 insurance." For consistency with modern usage, the
10 revised law substitutes "health" for "sickness"
11 throughout this chapter.

12 Revised Law

13 Sec. 1203.002. CERTAIN COORDINATION OF BENEFITS PROVISIONS
14 PROHIBITED. (a) An accident and health insurance policy or
15 evidence of coverage may not be delivered, issued for delivery, or
16 renewed in this state if:

17 (1) a provision of the policy or evidence of coverage
18 excludes or reduces the payment of benefits to or on behalf of an
19 insured or enrollee;

20 (2) the reason for the exclusion or reduction is that
21 benefits are also payable or have been paid to or on behalf of the
22 insured or enrollee under a supplemental policy of accident and
23 health insurance; and

24 (3) the supplemental policy is individually
25 underwritten and individually issued as a plan of coverage for:

26 (A) hospital confinement indemnity;

27 (B) a specified disease; or

28 (C) a limited benefit.

29 (b) Application of Subsection (a) to a provision of an
30 accident and health insurance policy or evidence of coverage is not
31 affected by:

32 (1) the mode or channel by which the premium for a
33 supplemental policy of accident and health insurance is paid to the
34 insurer; or

35 (2) a reduction in the premium for a supplemental
36 policy of accident and health insurance because of the insured's

1 membership in an organization or status as an employee. (V.T.I.C.
2 Art. 3.51-6B, Secs. 1(a) (part), (b).)

3 Source Law

4 (a) [A policy of group accident and health
5 insurance or blanket accident and health insurance as
6 defined by Sections 1 and 2, Article 3.51-6, Insurance
7 Code, an individual policy of accident and sickness
8 insurance as defined by Section 1(B)(3), Chapter 397,
9 Acts of the 54th Legislature, Regular Session, 1955
10 (Article 3.70-1, Vernon's Texas Insurance Code),
11 except an individual policy designed to fully
12 integrate with other policies through a variable
13 deductible, or an evidence of coverage as defined by
14 the Texas Health Maintenance Organization Act (Chapter
15 20A, Vernon's Texas Insurance Code),] may not be
16 delivered, issued for delivery, or renewed in this
17 state if the terms of the policy or evidence of
18 coverage exclude or reduce the payment of benefits to
19 or on behalf of an insured or enrollee because benefits
20 are also payable or have been paid under a supplemental
21 policy of accident and health insurance that is
22 individually underwritten and individually issued as a
23 hospital confinement indemnity, specified disease or
24 limited benefit plan of coverage.

25 (b) Subsection (a) of this section applies to
26 such supplemental policies irrespective of the mode or
27 channel of premium payment to the insurer and
28 regardless of any reduction in the premium by virtue of
29 the insured's membership in any organization or of his
30 status as an employee.

31 Revised Law

32 Sec. 1203.003. CERTAIN COORDINATION OF BENEFITS PROVISIONS
33 VOID. A provision of an accident and health insurance policy or
34 evidence of coverage that violates Section 1203.002 is void.
35 (V.T.I.C. Art. 3.51-6B, Sec. 2.)

36 Source Law

37 Sec. 2. A provision in a group accident and
38 health insurance or blanket accident and health
39 insurance policy, an individual accident and sickness
40 insurance policy, or an evidence of coverage that
41 violates Section 1 of this article is void.

42 CHAPTER 1204. PROCEDURES FOR PAYMENT OF CERTAIN HEALTH
43 AND ACCIDENT INSURANCE POLICY OR PLAN BENEFITS

44 SUBCHAPTER A. PAYMENTS TO CERTAIN PUBLIC HOSPITALS

45 Sec. 1204.001. NONAPPLICABILITY TO CERTAIN FACILITIES 640

46 Sec. 1204.002. BENEFITS PAYABLE FOR TREATMENT PROVIDED BY
47 HOSPITAL OWNED BY STATE OR UNIT OF
48 LOCAL GOVERNMENT 641

49 [Sections 1204.003-1204.050 reserved for expansion]

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1 CHAPTER 1204. PROCEDURES FOR PAYMENT OF CERTAIN HEALTH AND
2 ACCIDENT INSURANCE POLICY OR PLAN BENEFITS
3 SUBCHAPTER A. PAYMENTS TO CERTAIN PUBLIC HOSPITALS

4 Revised Law

5 Sec. 1204.001. NONAPPLICABILITY TO CERTAIN FACILITIES.
6 This subchapter does not apply to indigent care or chronic disease
7 care provided in or by an eleemosynary institution, sanitarium,
8 sanitorium, mental health treatment facility, tuberculosis
9 treatment facility, or cancer treatment facility that is owned or
10 controlled by the state or by a unit of local government. (V.T.I.C.
11 Art. 3.42B (part).)

12 Source Law

13 Art. 3.42B. . . .

14 The provisions of this article shall not apply to
15 indigent care nor to chronic disease care, in an
16 eleemosynary institution, sanitarium, sanitorium,
17 mental treatment facility of every type, tuberculosis
18 treatment facility of every type, and cancer treatment
19 facility of every type, where any such care is provided
20 in or by any such facility (regardless of the type or
21 name) owned or controlled by the state government or by
22 any unit of local government.

23 Revisor's Note

24 V.T.I.C. Article 3.42B refers to a "mental
25 treatment facility of every type, tuberculosis
26 treatment facility of every type, and cancer treatment
27 facility of every type . . . (regardless of the type or
28 name)." The revised law substitutes "mental health
29 treatment facility" for "mental treatment facility"
30 for consistency of terminology with the Health and
31 Safety Code. The revised law omits the references to
32 "of every type" and "regardless of the type or name"
33 because, for each category of facility listed, absent
34 an express limitation in the phrase describing the
35 category, the phrase describing the category of
36 facility includes a facility of any type or name in
37 that category.

1 Revised Law

2 Sec. 1204.002. BENEFITS PAYABLE FOR TREATMENT PROVIDED BY
3 HOSPITAL OWNED BY STATE OR UNIT OF LOCAL GOVERNMENT. An insurance
4 policy providing hospital, nursing, medical, or surgical coverage
5 that is issued or delivered in this state after August 27, 1973, may
6 not include a provision that prevents the payment of benefits for
7 expenses of a nonindigent patient incurred in a hospital facility
8 that:

9 (1) is owned or controlled by the state or by a unit of
10 local government; and

11 (2) regularly and customarily demands and collects
12 from nonindigent persons payment for those expenses. (V.T.I.C.
13 Art. 3.42B (part).)

14 Source Law

15 Art. 3.42B. After the effective date of this
16 Act, no insurance policy issued or delivered in this
17 state providing hospital, nursing, medical, or
18 surgical coverage may include a provision which would
19 prevent payment of benefits for expenses of a person
20 who is a non-indigent patient incurred in a hospital
21 facility owned or controlled by the state government
22 or by any unit of local government, provided charges
23 for such expenses are regularly and customarily
24 charged to and collected from non-indigent persons by
25 such hospital facility.

26 . . .

27 Revisor's Note

28 V.T.I.C. Article 3.42B refers to "the effective
29 date of this Act." The revised law substitutes for the
30 quoted language "August 27, 1973," the effective date
31 of the referenced act, which is Chapter 402, Acts of
32 the 63rd Legislature, Regular Session, 1973.

33 [Sections 1204.003-1204.050 reserved for expansion]

34 SUBCHAPTER B. ASSIGNMENT OF BENEFIT PAYMENTS

35 Revised Law

36 Sec. 1204.051. DEFINITIONS. In this subchapter:

37 (1) "Covered person" means a person who is insured or
38 covered by a health insurance policy or is a participant in an
39 employee benefit plan. The term includes:

1 (A) a person covered by a health insurance policy
2 because the person is an eligible dependent; and

3 (B) an eligible dependent of a participant in an
4 employee benefit plan.

5 (2) "Employee benefit plan" or "plan" means a plan,
6 fund, or program established or maintained by an employer, an
7 employee organization, or both, to the extent that it provides,
8 through the purchase of insurance or otherwise, health care
9 services to employees, participants, or the dependents of employees
10 or participants.

11 (3) "Health care provider" means a person who provides
12 health care services under a license, certificate, registration, or
13 other similar evidence of regulation issued by this or another
14 state of the United States.

15 (4) "Health care service" means a service to diagnose,
16 prevent, alleviate, cure, or heal a human illness or injury that is
17 provided to a covered person by a physician or other health care
18 provider.

19 (5) "Health insurance policy" means an individual,
20 group, blanket, or franchise insurance policy, or an insurance
21 agreement, that provides reimbursement or indemnity for health care
22 expenses incurred as a result of an accident or sickness.

23 (6) "Insurer" means an insurance company,
24 association, or organization authorized to engage in business in
25 this state under Chapter 841, 861, 881, 882, 883, 884, 885, 886,
26 887, 888, 941, 942, or 982.

27 (7) "Person" means an individual, association,
28 partnership, corporation, or other legal entity.

29 (8) "Physician" means an individual licensed to
30 practice medicine in this or another state of the United States.
31 (V.T.I.C. Art. 21.24-1, Sec. 1; New.)

32 Source Law

33 Art. 21.24-1

34 Sec. 1. In this article:

35 (1) "Covered person" means a person

1 insured or covered by a health insurance policy or a
2 participant in an employee benefit plan. The term
3 includes a person covered by a health insurance policy
4 because the person is an eligible dependent or an
5 eligible dependent of a participant in an employee
6 benefit plan.

7 (2) "Employee benefit plan" or "plan"
8 means a plan, fund, or program established or
9 maintained by an employer, an employee organization,
10 or both, to the extent that the plan, fund, or program
11 is established or maintained to provide health care
12 services to its employees, participants, or their
13 dependents through the purchase of insurance or
14 otherwise.

15 (3) "Health care provider" means a person
16 who furnishes health care services under a license,
17 certificate, registration, or other similar evidence
18 of regulation issued by this state or another state of
19 the United States.

20 (4) "Health care service" means a service
21 furnished to a covered person by a physician or other
22 health care provider to diagnose, prevent, alleviate,
23 cure, or heal a human illness or injury.

24 (5) "Health insurance policy" or "policy"
25 means an individual, group, blanket, or franchise
26 insurance policy, or insurance agreement that provides
27 reimbursement or indemnity for health care expenses
28 incurred as a result of an accident or sickness.

29 (6) "Insurer" means an insurance company,
30 association, or organization authorized to do business
31 in this state under Chapter 3, 8, 10, 11, 12, 13, 14,
32 15, 18, 19, or 22 of this code.

33 (7) "Physician" means an individual
34 licensed to practice medicine in this state or another
35 state of the United States.

36 (8) "Person" means an individual,
37 association, partnership, corporation, or other legal
38 entity.

39 Revisor's Note

40 Section 1(6), V.T.I.C. Article 21.24-1, refers to
41 Chapter 3 of the Insurance Code. The pertinent
42 portions of Chapter 3, relating to authorization of
43 domestic, foreign, and alien life, health, and
44 accident insurance companies, are revised in Chapters
45 841 and 982 of this code. The revised law is drafted
46 accordingly.

47 Revised Law

48 Sec. 1204.052. APPLICABILITY TO CERTAIN PLANS OR
49 PROGRAMS. This subchapter applies to:

50 (1) an employee benefit plan, to the extent not
51 preempted by the Employee Retirement Income Security Act of 1974
52 (29 U.S.C. Section 1001 et seq.);

53 (2) benefit programs under Chapters 1551 and 1601, to

1 the extent that the benefit programs are self-insuring; and

2 (3) insurance coverage provided under Chapter 1575.
3 (V.T.I.C. Art. 21.24-1, Sec. 2.)

4 Source Law

5 Sec. 2. (a) This article applies to employee
6 benefit plans to the extent the application of this
7 article to those plans is not preempted by the federal
8 Employee Retirement Income Security Act of 1974 (29
9 U.S.C. Section 1001 et seq.).

10 (b) This article applies to the Texas Employees
11 Uniform Group Insurance Benefits Act (Article 3.50-2,
12 Vernon's Texas Insurance Code) and the Texas State
13 College and University Employees Uniform Insurance
14 Benefits Act (Article 3.50-3, Vernon's Texas Insurance
15 Code) to the extent that benefit programs under those
16 Acts are self-insuring.

17 (c) This article applies to insurance coverage
18 provided under the Texas Public School Retired
19 Employees Group Insurance Act (Article 3.50-4,
20 Insurance Code).

21 Revised Law

22 Sec. 1204.053. ASSIGNMENT OF BENEFITS. (a) An insurer
23 may not deliver, renew, or issue for delivery in this state a health
24 insurance policy that prohibits or restricts a covered person from
25 making a written assignment of benefits to a physician or other
26 health care provider who provides health care services to the
27 person.

28 (b) This section does not:

29 (1) provide a coverage or benefit that is not
30 otherwise available under the health insurance policy;

31 (2) allow assignment of a benefit to:

32 (A) a person who is not legally entitled to
33 receive such a direct payment; or

34 (B) another person if, under the health insurance
35 policy or plan, the benefit must be provided to the covered person
36 by a physician or other health care provider who is a contractor or
37 preferred provider under the policy; or

38 (3) prohibit an insurer from verifying, through the
39 insurer's normal process, the health care services the physician or
40 other health care provider provides to the covered person.

41 (V.T.I.C. Art. 21.24-1, Sec. 3.)

1 Source Law

2 Sec. 3. (a) An insurer may not deliver, renew,
3 or issue for delivery a health insurance policy in this
4 state that prohibits or restricts the written
5 assignment by a covered person of benefits provided by
6 the policy for health care services to the physician or
7 other health care provider that furnishes those health
8 care services to the covered person.

9 (b) This section may not be construed to:

10 (1) provide a coverage or benefit not
11 otherwise available under the health insurance policy;

12 (2) allow assignment of a benefit to
13 another party if that benefit must be provided to the
14 covered person under the policy or plan by a physician
15 or a health care provider who is a contractor or
16 preferred provider under the policy;

17 (3) allow assignment of a benefit payment
18 to a person who is not legally entitled to receive such
19 a direct payment; or

20 (4) prohibit an insurer from verifying
21 through the insurer's normal process the health care
22 services provided to the covered person by the
23 physician or health care provider.

24 Revised Law

25 Sec. 1204.054. PAYMENT OF BENEFITS ACCORDING TO
26 ASSIGNMENT. An insurer shall pay benefits directly to a physician
27 or other health care provider, and the insurer is relieved of the
28 obligation to pay, and of any liability for paying, those benefits
29 to the covered person if:

30 (1) the covered person makes a written assignment of
31 those benefits payable to the physician or other health care
32 provider; and

33 (2) the assignment is obtained by or delivered to the
34 insurer with the claim for benefits. (V.T.I.C. Art. 21.24-1, Secs.
35 4(a), (b).)

36 Source Law

37 Sec. 4. (a) If a written assignment of
38 benefits payable for health care services is made by a
39 covered person and is obtained by or delivered to the
40 insurer with the claim for benefits, the benefit
41 payment shall be made by the insurer directly to the
42 physician or other health care provider.

43 (b) If a written assignment of benefits is made
44 and delivered or obtained as provided by this section,
45 the insurer is relieved of the obligation to pay and of
46 any liability for paying the benefits for the health
47 care services to the covered person.

48 Revised Law

49 Sec. 1204.055. CONTRACTUAL RESPONSIBILITY FOR DEDUCTIBLES
50 AND COPAYMENTS. (a) The payment of benefits under an assignment

1 does not relieve a covered person of a contractual obligation to pay
2 a deductible or copayment.

3 (b) A physician or other health care provider may not waive
4 a deductible or copayment by the acceptance of an assignment.
5 (V.T.I.C. Art. 21.24-1, Sec. 4(c).)

6 Source Law

7 (c) The payment of benefits under an assignment
8 does not relieve the covered person of any contractual
9 responsibility for the payment of deductibles and
10 copayments. A physician or other health care provider
11 may not waive copayments or deductibles by acceptance
12 of an assignment.

13 [Sections 1204.056-1204.100 reserved for expansion]

14 SUBCHAPTER C. UNIFORM CLAIM BILLING FORMS

15 Revised Law

16 Sec. 1204.101. DEFINITIONS. In this subchapter:

17 (1) "Health benefit plan" means a group, blanket, or
18 franchise insurance policy, a group hospital service contract, or a
19 group subscriber contract or evidence of coverage issued by a
20 health maintenance organization, that provides benefits for health
21 care services.

22 (2) "Health benefit plan issuer" means an entity
23 authorized under this code or another insurance law of this state
24 that provides health insurance or health benefits in this state,
25 including:

26 (A) an insurance company;

27 (B) a group hospital service corporation
28 operating under Chapter 842;

29 (C) a health maintenance organization operating
30 under Chapter 843; and

31 (D) a stipulated premium company operating under
32 Chapter 884.

33 (3) "Provider" means a person who provides health care
34 under a license issued by this state. The term includes a health
35 care practitioner listed in Section 1451.001 and a nurse first
36 assistant, as defined by Section 1451.101. (V.T.I.C. Art. 21.52C,

1 Sec. (a).)

2 Source Law

3 Art. 21.52C. (a) In this article:

4 (1) "Health benefit plan" means a group,
5 blanket, or franchise insurance policy, a group
6 hospital service contract, or a group subscriber
7 contract or evidence of coverage issued by a health
8 maintenance organization that provides benefits for
9 health care services.

10 (2) "Health carrier" means any entity
11 authorized under this code or another insurance law of
12 this state that provides health insurance or health
13 benefits in this state, including an insurance
14 company, a group hospital service corporation under
15 Chapter 20 of this code, a health maintenance
16 organization under the Texas Health Maintenance
17 Organization Act (Chapter 20A, Vernon's Texas
18 Insurance Code), and a stipulated premium company
19 authorized under Chapter 22 of this code.

20 (3) "Provider" means a person who provides
21 health care under a license issued by this state,
22 including a person listed in Section 2(B), Chapter
23 397, Acts of the 54th Legislature, Regular Session,
24 1955 (Article 3.70-2, Vernon's Texas Insurance Code),
25 or in Article 21.52 of this code.

26 Revisor's Note

27 Section (a), V.T.I.C. Article 21.52C, defines
28 "health carrier." "Carrier" is a term used in
29 conjunction with traditional insurance. Included in
30 the definition of "health carrier" are entities such
31 as health maintenance organizations that are not
32 insurers. Consequently, "benefit plan issuer" is a
33 more accurate term than "carrier," and the revised law
34 substitutes "health benefit plan issuer" for "health
35 carrier."

36 Revised Law

37 Sec. 1204.102. REQUIRED CLAIM BILLING FORMS. A provider
38 who seeks payment or reimbursement under a health benefit plan and
39 the health benefit plan issuer that issued the plan shall use
40 uniform claim billing form UB-82/HCFR or HCFR 1500, or a successor
41 to one of those forms, as developed by the National Uniform Billing
42 Committee or its successor. (V.T.I.C. Art. 21.52C, Sec. (b).)

43 Source Law

44 (b) A provider seeking payment or reimbursement
45 under a health benefit plan and the health carrier that
46 issued that plan must use uniform claim billing form

1 UB-82/HCFAs or HCFA 1500, or their successors, as
2 developed by the National Uniform Billing Committee or
3 its successor.

4 [Sections 1204.103-1204.150 reserved for expansion]

5 SUBCHAPTER D. PAYMENTS FOR CERTAIN PUBLICLY PROVIDED SERVICES

6 Revised Law

7 Sec. 1204.151. DEFINITION. In this subchapter, "policy"
8 means an individual or group policy of accident and health
9 insurance, including a policy issued by a group hospital service
10 corporation operating under Chapter 842. (V.T.I.C. Art. 3.76, Sec.
11 1 (part); Art. 21.49-10 (part).)

12 Source Law

13 Art. 3.76

14 Sec. 1. Each individual or group policy of
15 accident and sickness insurance, including a policy
16 issued by a company subject to Chapter 20 of this
17 code

18 Art. 21.49-10. Each individual policy or group
19 policy of accident or sickness insurance, including
20 policies issued by companies subject to Chapter 20 of
21 this Code

22 Revisor's Note

23 (1) The definition of "policy" is derived from
24 Section 1, V.T.I.C. Article 3.76, and V.T.I.C. Article
25 21.49-10. The relevant portions of those laws have
26 been revised as a definition for drafting convenience
27 and to avoid unnecessary repetition of the substance
28 of the definition.

29 (2) Section 1, V.T.I.C. Article 3.76, refers to
30 "accident and sickness insurance" and V.T.I.C. Article
31 21.49-10 refers to "accident or sickness insurance."
32 Throughout this chapter, the revised law substitutes
33 for those terms "accident and health insurance" for
34 consistency with modern usage.

35 (3) Section 1, V.T.I.C. Article 3.76, refers to
36 a "company subject to Chapter 20 of this code," and
37 V.T.I.C. Article 21.49-10 refers to "companies subject
38 to Chapter 20 of this Code." In each instance, the
39 quoted language refers to a corporation operating

1 under V.T.I.C. Chapter 20, revised as Chapter 842 of
2 this code. The term most frequently used to refer to
3 such a corporation is "group hospital service
4 corporation." Consequently, the revised law
5 substitutes for the quoted language "group hospital
6 service corporation" to provide for consistent use of
7 terminology throughout this code. Similar changes are
8 made throughout this chapter.

9 Revised Law

10 Sec. 1204.152. PAYMENT FOR CERTAIN EXPENSES INCURRED BY
11 TEXAS DEPARTMENT OF HUMAN SERVICES. Each policy delivered or
12 issued for delivery in this state must provide for the repayment of
13 the actual costs of medical expenses the Texas Department of Human
14 Services pays through medical assistance for an insured person if,
15 under the policy, the insured person is entitled to payment for the
16 medical expenses. (V.T.I.C. Art. 21.49-10 (part).)

17 Source Law

18 Art. 21.49-10. [Each individual policy or group
19 policy of accident or sickness insurance, including
20 policies issued by companies subject to Chapter 20 of
21 this Code], delivered or issued for delivery to any
22 person in this state shall provide for payment to the
23 Texas Department of Human Resources for the actual
24 cost of medical expenses the department pays through
25 medical assistance for a person insured by the
26 contract if the insured is entitled to payment for the
27 medical expenses by the insurance contract.

28 Revisor's Note

29 V.T.I.C. Article 21.49-10 refers to the "Texas
30 Department of Human Resources." Section 1, Chapter
31 264, Acts of the 69th Legislature, Regular Session,
32 1985, changed the name of that agency to the Texas
33 Department of Human Services. The revised law is
34 drafted accordingly.

35 Revised Law

36 Sec. 1204.153. PAYMENTS TO TEXAS DEPARTMENT OF HUMAN
37 SERVICES FOR CERTAIN CHILDREN. (a) This section applies only to a
38 policy that is delivered, issued for delivery, or renewed in this

1 state and that provides coverage for a child whose parent:

2 (1) purchased the policy; or

3 (2) is a member of the group covered under the policy.

4 (b) Each policy must include a requirement that, after
5 written notice to the insurer or group hospital service corporation
6 at the insurer's or group hospital service corporation's home
7 office, benefits payable on behalf of a child must be paid to the
8 Texas Department of Human Services if:

9 (1) the parent who purchased the policy or who is a
10 group member is required to pay child support by a court order or
11 court-approved agreement and:

12 (A) is a possessory conservator of the child
13 under a court order issued in this state; or

14 (B) is not entitled to possession of or access to
15 the child;

16 (2) the Texas Department of Human Services is paying
17 benefits on behalf of the child under Chapter 31 or 32, Human
18 Resources Code; and

19 (3) the insurer or group hospital service corporation
20 is notified, through an attachment to the claim for benefits at the
21 time the claim is first submitted to the insurer or group hospital
22 service corporation, that the benefits must be paid directly to the
23 Texas Department of Human Services.

24 (c) The commissioner and the Texas Department of Human
25 Services may consult regarding implementation of this section.

26 (V.T.I.C. Art. 3.76, Secs. 1 (part), 2.)

27 Source Law

28 Sec. 1. [Each individual or group policy of
29 accident and sickness insurance, including a policy
30 issued by a company subject to Chapter 20 of this
31 code], that is delivered, issued for delivery, or
32 renewed in this state and that provides coverage for
33 one or more children whose parent purchased the policy
34 or whose parent is a member of the group shall include
35 a requirement that benefits paid on behalf of the child
36 or children under the policy must be paid to the Texas
37 Department of Human Services after written notice to
38 the insurer at the insurer's home office, if:

39 (1) the parent who purchased the policy or
40 who is a member of the group is:

1 (A) a possessory conservator of the
2 child under an order issued by a court in this state or
3 is not entitled to possession of or access to the
4 child; and

5 (B) is required by court order or
6 court-approved agreement to pay child support;

7 (2) the Texas Department of Human Services
8 is paying benefits on behalf of the child under Chapter
9 31 or Chapter 32, Human Resources Code; and

10 (3) the insurer or group hospital service
11 company is notified through an attachment to the claim
12 for insurance benefits when the claim is first
13 submitted to the insurer or company that the benefits
14 must be paid directly to the Texas Department of Human
15 Services.

16 Sec. 2. The State Board of Insurance and the
17 Texas Department of Human Services may consult with
18 regard to the implementation of this article.

19 Revisor's Note

20 Section 2, V.T.I.C. Article 3.76, refers to the
21 State Board of Insurance. Chapter 685, Acts of the
22 73rd Legislature, Regular Session, 1993, abolished the
23 board and transferred its functions to the
24 commissioner of insurance and the Texas Department of
25 Insurance. Throughout this chapter, references to the
26 board have been changed appropriately.

27 Revised Law

28 Sec. 1204.154. UNIFORM PROVISIONS. (a) The commissioner
29 shall adopt uniform policy provisions, riders, and endorsements for
30 the policy requirement of Section 1204.153.

31 (b) Before the commissioner adopts or makes a change to a
32 provision, rider, or endorsement under Subsection (a), the
33 commissioner shall present each provision, rider, or endorsement,
34 and any amendment to a provision, rider, or endorsement, to the
35 Texas Department of Human Services for comment. (V.T.I.C. Art.
36 3.76, Sec. 3.)

37 Source Law

38 Sec. 3. The State Board of Insurance shall
39 prescribe uniform policy provisions, riders, and
40 endorsements for the policy requirement provided by
41 Section 1 of this article. Before the board prescribes
42 any provisions, riders, or endorsements or any changes
43 in provisions, riders, or endorsements, the State
44 Board of Insurance shall submit the provisions,
45 riders, or endorsements or amendments to them to the
46 Texas Department of Human Services for comment.

47 [Sections 1204.155-1204.200 reserved for expansion]

1 SUBCHAPTER E. EXCLUSIONARY CLAUSES

2 Revised Law

3 Sec. 1204.201. PROHIBITION OF EXCLUSION OF CERTAIN MEDICAL
4 ASSISTANCE BENEFITS. An individual or group accident and health
5 insurance policy delivered or issued for delivery in this state,
6 including a policy issued by a group hospital service corporation
7 operating under Chapter 842, may not include a provision that
8 excludes or limits the insurer's or group hospital service
9 corporation's coverage from paying benefits covered by Chapter 32,
10 Human Resources Code. (V.T.I.C. Art. 21.49-9.)

11 Source Law

12 Art. 21.49-9. No individual policy or group
13 policy of accident or sickness insurance, including
14 policies issued by companies subject to Chapter 20 of
15 this code, delivered or issued for delivery to any
16 person in this state, may include a provision that
17 excludes or limits coverage of the insurer from paying
18 benefits covered by The Medical Assistance Act of
19 1967, as amended (Article 695j-1, Vernon's Texas Civil
20 Statutes).

21 Revisor's Note

22 V.T.I.C. Article 21.49-9 refers to "The Medical
23 Assistance Act of 1967, as amended (Article 695j-1,
24 Vernon's Texas Civil Statutes)." The revised law
25 substitutes for that reference a reference to Chapter
26 32, Human Resources Code, which contains the substance
27 of that article.

28 [Sections 1204.202-1204.250 reserved for expansion]

29 SUBCHAPTER F. PAYMENT OF BENEFITS TO CONSERVATOR OF MINOR

30 Revised Law

31 Sec. 1204.251. PAYMENT TO CONSERVATOR OTHER THAN GROUP
32 MEMBER. (a) An insurer or group hospital service corporation
33 operating under Chapter 842 that delivers, issues for delivery, or
34 renews in this state a group accident and health insurance policy
35 that provides coverage for a minor child who qualifies as a
36 dependent of a group member may pay benefits on the child's behalf
37 to a person who is not a group member if an order providing for the
38 appointment of a possessory or managing conservator of the child

1 has been issued by a court in this or another state.

2 (b) A person who is not a group member is entitled to be paid
3 benefits under this section only if the person presents to the
4 insurer or group hospital service corporation, with the claim
5 application:

6 (1) written notice that the person is a possessory or
7 managing conservator of the child on whose behalf the claim is made;
8 and

9 (2) a certified copy of a court order designating the
10 person as possessory or managing conservator of the child or other
11 evidence designated by rule of the commissioner that the person is
12 eligible for the benefits as this section provides. (V.T.I.C. Art.
13 3.51-13, Secs. 1, 3.)

14 Source Law

15 Art. 3.51-13

16 Sec. 1. An insurer or group hospital service
17 company that delivers, issues for delivery, or renews
18 a group accident and sickness insurance policy in this
19 state, including a policy issued by a company subject
20 to Chapter 20 of this code, that provides coverage for
21 a minor child who otherwise qualifies as a dependent of
22 a person who is a member of the group may pay benefits
23 on behalf of the child to the person who is not a member
24 of the group if a court order providing for the
25 appointment of a possessory or managing conservator of
26 the child has been issued by a court of competent
27 jurisdiction in this or any other state.

28 Sec. 3. Before a person who is not a member of a
29 group is entitled to be paid benefits under Section 1
30 of this article, the person must submit to the insurer
31 or company with the claim application written notice
32 that the person:

33 (1) is a possessory or managing
34 conservator of the child on whose behalf the claim is
35 made; and

36 (2) submit a certified copy of a court
37 order establishing the person as possessory or
38 managing conservator or other evidence designated by
39 rule of the State Board of Insurance that the person
40 qualifies to be paid the benefits as provided by this
41 article.

42 Revisor's Note

43 Section 1, V.T.I.C. Article 3.51-13, refers to an
44 order for conservatorship of a child issued by a court
45 "of competent jurisdiction." The revised law omits
46 the quoted language as unnecessary because the

1 constitutions and general laws of civil jurisdiction
2 of this state and other states determine which courts
3 have jurisdiction over such matters.

4 Revised Law

5 Sec. 1204.252. PRECONDITIONS FOR PAYMENT; EXCEPTIONS. (a)
6 In accordance with the terms of the policy and this subchapter, an
7 insurer or group hospital service corporation may be required to
8 pay benefits under a group accident and health insurance policy to a
9 person who is not a group member and who complies with:

10 (1) Section 1204.251;

11 (2) the insurer's or group hospital service
12 corporation's claim application procedures; and

13 (3) department rules.

14 (b) Any requirement imposed on a possessory or managing
15 conservator of a child under this subchapter does not apply with
16 regard to:

17 (1) an unpaid medical bill for which an assignment of
18 benefits has been exercised, whether in accordance with policy
19 provisions or otherwise; or

20 (2) a claim presented by a group member for which the
21 group member paid any portion of a medical bill that is covered
22 under the policy's terms. (V.T.I.C. Art. 3.51-13, Sec. 2.)

23 Source Law

24 Sec. 2. A group accident and sickness insurance
25 policy issued by an insurer or group hospital service
26 company may be required to pay benefits pursuant to the
27 terms of the policy and as provided by this article on
28 compliance by the person who is not a member of the
29 group with the requirements of this article, claim
30 application procedures of the insurer or company, and
31 rules of the State Board of Insurance. However, any
32 requirements imposed on a possessory or managing
33 conservator of the child shall not apply in the case of
34 any unpaid medical bill for which a valid assignment of
35 benefits has been exercised in accordance with policy
36 provisions or otherwise, nor to claims submitted by
37 the group member where the group member has paid any
38 portion of a medical bill that would be covered under
39 the terms of the policy.

40 Revisor's Note

41 Section 2, V.T.I.C. Article 3.51-13, refers to a

1 "valid assignment of benefits." The revised law omits
2 "valid" as unnecessary because the word does not add to
3 the clear meaning of the law. A forged assignment or
4 an attempted assignment that does not meet the legal
5 requirements of an enforceable assignment is not
6 considered an assignment.

7 Revised Law

8 Sec. 1204.253. RULES. The commissioner may adopt rules to
9 ensure the effective implementation of this subchapter. (V.T.I.C.
10 Art. 3.51-13, Sec. 4.)

11 Source Law

12 Sec. 4. The State Board of Insurance may adopt
13 rules to assure the effective implementation of this
14 article.

15 CHAPTER 1205. CERTIFICATION OF CREDITABLE COVERAGE

16 Sec. 1205.001. APPLICABILITY OF CHAPTER 655
17 Sec. 1205.002. CERTIFICATION OF COVERAGE 658
18 Sec. 1205.003. RULES 658
19 Sec. 1205.004. CREDITABLE COVERAGE 658

20 CHAPTER 1205. CERTIFICATION OF CREDITABLE COVERAGE

21 Revised Law

22 Sec. 1205.001. APPLICABILITY OF CHAPTER. This chapter
23 applies only to a health benefit plan that:

24 (1) provides benefits for medical or surgical expenses
25 incurred as a result of a health condition, accident, or sickness,
26 including:

27 (A) an individual, group, blanket, or franchise
28 insurance policy or insurance agreement, a group hospital service
29 contract, or an individual or group evidence of coverage that is
30 offered by:

- 31 (i) an insurance company;
- 32 (ii) a group hospital service corporation
33 operating under Chapter 842;
- 34 (iii) a fraternal benefit society operating
35 under Chapter 885;

1 (iv) a stipulated premium company operating
2 under Chapter 884; or

3 (v) a health maintenance organization
4 operating under Chapter 843; and

5 (B) to the extent permitted by the Employee
6 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et
7 seq.), a health benefit plan that is offered by:

8 (i) a multiple employer welfare arrangement
9 as defined by Section 3 of that Act and operating under Chapter 846;
10 or

11 (ii) an analogous benefit arrangement;

12 (2) is offered by an approved nonprofit health
13 corporation that holds a certificate of authority under Chapter
14 844; or

15 (3) is offered by any other entity that:

16 (A) is not authorized under this code or another
17 insurance law of this state; and

18 (B) contracts directly for health care services
19 on a risk-sharing basis, including a capitation basis. (V.T.I.C.
20 Art. 21.52G, Sec. 2, as added Acts 75th Leg., R.S., Ch. 955.)

21 Source Law

22 Sec. 2. This article applies to a health benefit
23 plan that:

24 (1) provides benefits for medical or
25 surgical expenses incurred as a result of a health
26 condition, accident, or sickness, including:

27 (A) an individual, group, blanket, or
28 franchise insurance policy or insurance agreement, a
29 group hospital service contract, or an individual or
30 group evidence of coverage that is offered by:

31 (i) an insurance company;

32 (ii) a group hospital service
33 corporation operating under Chapter 20 of this code;

34 (iii) a fraternal benefit
35 society operating under Chapter 10 of this code;

36 (iv) a stipulated premium
37 insurance company operating under Chapter 22 of this
38 code; or

39 (v) a health maintenance
40 organization operating under the Texas Health
41 Maintenance Organization Act (Chapter 20A, Vernon's
42 Texas Insurance Code); or

43 (B) to the extent permitted by the
44 Employee Retirement Income Security Act of 1974 (29
45 U.S.C. Section 1001 et seq.), a health benefit plan
46 that is offered by:

1 (i) a multiple employer welfare
2 arrangement as defined by Section 3, Employee
3 Retirement Income Security Act of 1974 (29 U.S.C.
4 Section 1002), and operating under Article 3.95-1 et
5 seq. of this code; or

6 (ii) another analogous benefit
7 arrangement;

8 (2) is offered by an approved nonprofit
9 health corporation that is certified under Section
10 5.01(a), Medical Practice Act (Article 4495b, Vernon's
11 Texas Civil Statutes), and that holds a certificate of
12 authority issued by the commissioner under Article
13 21.52F of this code; or

14 (3) is offered by any other entity not
15 licensed under this code or another insurance law of
16 this state that contracts directly for health care
17 services on a risk-sharing basis, including an entity
18 that contracts for health care services on a
19 capitation basis.

20 Revisor's Note

21 (1) Section 2(2), V.T.I.C. Article 21.52G, as
22 added by Chapter 955, Acts of the 75th Legislature,
23 Regular Session, 1997, refers to a health benefit plan
24 offered by a nonprofit corporation "certified under
25 Section 5.01(a), Medical Practice Act," and holding a
26 certificate of authority "issued by the commissioner
27 under Article 21.52F." The revised law omits the
28 reference to certification under Section 5.01(a),
29 Medical Practice Act (Article 4495b, Vernon's Texas
30 Civil Statutes), which was codified in 1999 in Chapter
31 162, Occupations Code, as unnecessary because V.T.I.C.
32 Article 21.52F, revised as Chapter 844 of this code,
33 requires a nonprofit corporation to be certified under
34 that provision as a condition of holding a certificate
35 of authority. The revised law also omits as
36 unnecessary the reference to the commissioner issuing
37 the certificate of authority because Article 21.52F,
38 as revised, requires the commissioner to issue the
39 certificate of authority.

40 (2) Section 2(3), V.T.I.C. Article 21.52G, as
41 added by Chapter 955, Acts of the 75th Legislature,
42 Regular Session, 1997, refers to a health benefit plan
43 offered by an entity not "licensed" under this code or

1 another insurance law of this state. The revised law
2 substitutes "authorized" for "licensed" for
3 consistency with terminology used throughout this
4 code.

5 Revised Law

6 Sec. 1205.002. CERTIFICATION OF COVERAGE. (a) A health
7 benefit plan issuer shall provide a certification of coverage as
8 necessary to determine the period of applicable creditable coverage
9 under that health benefit plan.

10 (b) The certification required under this section must be
11 provided in accordance with the standards adopted by rule by the
12 commissioner. (V.T.I.C. Art. 21.52G, Sec. 4, as added Acts 75th
13 Leg., R.S., Ch. 955.)

14 Source Law

15 Sec. 4. Each issuer of a health benefit plan
16 shall provide a certification of coverage, in
17 accordance with the standards the commissioner adopts
18 by rule, as necessary to determine the period of
19 applicable creditable coverage of health benefit
20 plans.

21 Revised Law

22 Sec. 1205.003. RULES. The commissioner shall adopt rules
23 as necessary to:

24 (1) implement this chapter and related provisions of
25 this code; and

26 (2) meet the minimum requirements of federal law,
27 including regulations. (V.T.I.C. Art. 21.52G, Sec. 5, as added
28 Acts 75th Leg., R.S., Ch. 955.)

29 Source Law

30 Sec. 5. The commissioner shall adopt rules as
31 necessary to implement this article and related
32 provisions of this code and to meet the minimum
33 requirements of federal law and regulations.

34 Revised Law

35 Sec. 1205.004. CREDITABLE COVERAGE. (a) An individual's
36 coverage is creditable coverage for purposes of this chapter if the
37 coverage is provided under:

38 (1) a self-funded or self-insured employee welfare

1 benefit plan that:

2 (A) provides health benefits; and

3 (B) is established in accordance with the
4 Employee Retirement Income Security Act of 1974 (29 U.S.C. Section
5 1001 et seq.);

6 (2) a group health benefit plan provided by a health
7 insurer or health maintenance organization;

8 (3) an individual health insurance policy or evidence
9 of coverage;

10 (4) Part A or Part B of Title XVIII of the Social
11 Security Act (42 U.S.C. Section 1395c et seq.);

12 (5) Title XIX of the Social Security Act (42 U.S.C.
13 Section 1396 et seq.), other than coverage consisting solely of
14 benefits under Section 1928 of that act (42 U.S.C. Section 1396s);

15 (6) 10 U.S.C. Section 1071 et seq.;

16 (7) a medical care program of the Indian Health
17 Service or of a tribal organization;

18 (8) a state health benefits risk pool;

19 (9) a health plan offered under 5 U.S.C. Section 8901
20 et seq.;

21 (10) a public health plan as defined by federal
22 regulations; or

23 (11) a health benefit plan under Section 5(e), Peace
24 Corps Act (22 U.S.C. Section 2504(e)).

25 (b) For purposes of this chapter, creditable coverage does
26 not include:

27 (1) accident-only or disability income insurance or a
28 combination of accident-only and disability income insurance;

29 (2) coverage issued as a supplement to liability
30 insurance;

31 (3) liability insurance, including general liability
32 insurance and automobile liability insurance;

33 (4) workers' compensation insurance or other similar
34 insurance;

- 1 (5) automobile medical payment insurance;
2 (6) credit-only insurance;
3 (7) coverage for on-site medical clinics;
4 (8) other coverage that is:
5 (A) similar to the coverage described by this
6 subsection under which benefits for medical care are secondary or
7 incidental to other insurance benefits; and
8 (B) specified by federal regulations;
9 (9) coverage that provides limited-scope dental or
10 vision benefits;
11 (10) long-term care, nursing home care, home health
12 care, or community-based care coverage or benefits or any
13 combination of those coverages or benefits;
14 (11) coverage that provides other limited benefits
15 specified by federal regulations;
16 (12) coverage for a specified disease or illness;
17 (13) hospital indemnity or other fixed indemnity
18 insurance; or
19 (14) Medicare supplemental health insurance, as
20 defined by Section 1882(g)(1), Social Security Act (42 U.S.C.
21 Section 1395ss), coverage supplemental to the coverage provided
22 under 10 U.S.C. Section 1071 et seq., or other similar supplemental
23 coverage provided under a group plan. (V.T.I.C. Art. 21.52G, Sec.
24 3, as added Acts 75th Leg., R.S., Ch. 955.)

25 Source Law

26 Sec. 3. (a) An individual's coverage is
27 creditable for purposes of this article if the
28 coverage is provided under:

29 (1) a self-funded or self-insured employee
30 welfare benefit plan that provides health benefits and
31 that is established in accordance with the Employee
32 Retirement Income Security Act of 1974 (29 U.S.C.
33 Section 1001 et seq.);

34 (2) a group health benefit plan provided
35 by a health insurance carrier or health maintenance
36 organization;

37 (3) an individual health insurance policy
38 or evidence of coverage;

39 (4) Part A or Part B of Title XVIII of the
40 Social Security Act (42 U.S.C. Section 1395c et seq.);

41 (5) Title XIX of the Social Security Act
42 (42 U.S.C. Section 1396 et seq.), other than coverage

1 consisting solely of benefits under Section 1928 of
2 that Act (42 U.S.C. Section 1396s);
3 (6) Chapter 55, Title 10, United States
4 Code (10 U.S.C. Section 1071 et seq.);
5 (7) a medical care program of the Indian
6 Health Service or of a tribal organization;
7 (8) a state health benefits risk pool;
8 (9) a health plan offered under Chapter
9 89, Title 5, United States Code (5 U.S.C. Section 8901
10 et seq.);
11 (10) a public health plan as defined by
12 federal regulations; or
13 (11) a health benefit plan under Section
14 5(e), Peace Corps Act (22 U.S.C. Section 2504(e)).
15 (b) Creditable coverage does not include:
16 (1) accident-only or disability income
17 insurance, or a combination of accident-only and
18 disability income insurance;
19 (2) coverage issued as a supplement to
20 liability insurance;
21 (3) liability insurance, including
22 general liability insurance and automobile liability
23 insurance;
24 (4) workers' compensation or similar
25 insurance;
26 (5) automobile medical payment insurance;
27 (6) credit-only insurance;
28 (7) coverage for on-site medical clinics;
29 (8) other coverage that is:
30 (A) similar to the coverage described
31 in this subsection under which benefits for medical
32 care are secondary or incidental to other insurance
33 benefits; and
34 (B) specified in federal
35 regulations;
36 (9) coverage that provides limited-scope
37 dental or vision benefits;
38 (10) long-term care coverage or benefits,
39 nursing home care coverage or benefits, home health
40 care coverage or benefits, community-based care
41 coverage or benefits, or any combination of those
42 coverages or benefits;
43 (11) coverage that provides other limited
44 benefits specified by federal regulations;
45 (12) coverage for a specified disease or
46 illness;
47 (13) hospital indemnity or other fixed
48 indemnity insurance; or
49 (14) Medicare supplemental health
50 insurance as defined under Section 1882(g)(1), Social
51 Security Act (42 U.S.C. Section 1395ss), coverage
52 supplemental to the coverage provided under Chapter
53 55, Title 10, United States Code (10 U.S.C. Section
54 1071 et seq.), and similar supplemental coverage
55 provided under a group plan.

56 Revisor's Note
57 (End of Chapter)

58 Section 1, V.T.I.C. Article 21.52G, as added by
59 Chapter 955, Acts of the 75th Legislature, Regular
60 Session, 1997, defines "creditable coverage" and
61 "health benefit plan." The revised law omits those
62 definitions as unnecessary because Section 3 of that

1 article, revised as Section 1205.004, specifies the
2 type of coverage that is creditable coverage for
3 purposes of the chapter, and Section 2 of that article,
4 revised as Section 1205.001, specifies the types of
5 health benefit plans to which the chapter applies. The
6 defined terms are thus not helpful to the reader. The
7 omitted law reads:

8 Art. 21.52G

9 Sec. 1. In this article:

10 (1) "Creditable coverage" means
11 creditable coverage described by Section 3
12 of this article.

13 (2) "Health benefit plan" means
14 a plan subject to this article under Section
15 2 of this article.

16 CHAPTER 1206. DENIAL OF HEALTH BENEFIT PLAN ENROLLMENT BASED
17 ON EXISTING COVERAGE PROHIBITED

18 Sec. 1206.001. APPLICABILITY OF CHAPTER 662
19 Sec. 1206.002. EXCEPTION. 663
20 Sec. 1206.003. DENIAL OF ENROLLMENT PROHIBITED 665
21 Sec. 1206.004. VIOLATION OF CHAPTER: UNFAIR
22 DISCRIMINATION 665

23 CHAPTER 1206. DENIAL OF HEALTH BENEFIT PLAN ENROLLMENT BASED
24 ON EXISTING COVERAGE PROHIBITED

25 Revised Law

26 Sec. 1206.001. APPLICABILITY OF CHAPTER. This chapter
27 applies only to a health benefit plan, including a small employer
28 health benefit plan written under Chapter 1501, that provides
29 benefits for medical or surgical expenses incurred as a result of a
30 health condition, accident, or sickness, including an individual,
31 group, blanket, or franchise insurance policy or insurance
32 agreement, a group hospital service contract, or an individual or
33 group evidence of coverage or similar coverage document that is
34 offered by:

35 (1) an insurance company;

36 (2) a group hospital service corporation operating
37 under Chapter 842;

1 (3) a fraternal benefit society operating under
2 Chapter 885;

3 (4) a stipulated premium company operating under
4 Chapter 884;

5 (5) a reciprocal exchange operating under Chapter 942;

6 (6) a health maintenance organization operating under
7 Chapter 843;

8 (7) a multiple employer welfare arrangement that holds
9 a certificate of authority under Chapter 846; or

10 (8) an approved nonprofit health corporation that
11 holds a certificate of authority under Chapter 844. (V.T.I.C.
12 Art. 21.52L, Secs. 1(a), (b), as added Acts 77th Leg., R.S., Ch.
13 1074.)

14 Source Law

15 Art. 21.52L

16 Sec. 1. (a) This article applies only to a
17 health benefit plan that provides benefits for medical
18 or surgical expenses incurred as a result of a health
19 condition, accident, or sickness, including an
20 individual, group, blanket, or franchise insurance
21 policy or insurance agreement, a group hospital
22 service contract, or an individual or group evidence
23 of coverage or similar coverage document that is
24 offered by:

25 (1) an insurance company;

26 (2) a group hospital service corporation
27 operating under Chapter 20 of this code;

28 (3) a fraternal benefit society operating
29 under Chapter 10 of this code;

30 (4) a stipulated premium insurance company
31 operating under Chapter 22 of this code;

32 (5) a reciprocal exchange operating under
33 Chapter 19 of this code;

34 (6) a health maintenance organization
35 operating under the Texas Health Maintenance
36 Organization Act (Chapter 20A, Vernon's Texas
37 Insurance Code);

38 (7) a multiple employer welfare
39 arrangement that holds a certificate of authority
40 under Article 3.95-2 of this code; or

41 (8) an approved nonprofit health
42 corporation that holds a certificate of authority
43 under Article 21.52F of this code.

44 (b) This article applies to a small employer
45 health benefit plan written under Chapter 26 of this
46 code.

47 Revised Law

48 Sec. 1206.002. EXCEPTION. This chapter does not apply to:

49 (1) a plan that provides coverage:

1 (A) only for a specified disease or for another
2 limited benefit;
3 (B) only for accidental death or dismemberment;
4 (C) for wages or payments in lieu of wages for a
5 period during which an employee is absent from work because of
6 sickness or injury;
7 (D) as a supplement to a liability insurance
8 policy;
9 (E) for credit insurance;
10 (F) only for dental or vision care;
11 (G) only for hospital expenses;
12 (H) only for indemnity for hospital confinement;
13 or
14 (I) in accordance with Title XXI of the Social
15 Security Act (42 U.S.C. Section 1397aa et seq.);
16 (2) a Medicare supplemental policy as defined by
17 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),
18 as amended;
19 (3) a workers' compensation insurance policy;
20 (4) medical payment insurance coverage provided under
21 a motor vehicle insurance policy; or
22 (5) a long-term care insurance policy, including a
23 nursing home fixed indemnity policy, unless the commissioner
24 determines that the policy provides benefit coverage so
25 comprehensive that the policy is a health benefit plan as described
26 by Section 1206.001. (V.T.I.C. Art. 21.52L, Sec. 1(c), as added
27 Acts 77th Leg., R.S., Ch. 1074.)

28 Source Law

29 (c) This article does not apply to:
30 (1) a plan that provides coverage:
31 (A) only for benefits for a specified
32 disease or for another limited benefit;
33 (B) only for accidental death or
34 dismemberment;
35 (C) for wages or payments in lieu of
36 wages for a period during which an employee is absent
37 from work because of sickness or injury;
38 (D) as a supplement to a liability
39 insurance policy;

1 (E) for credit insurance;
2 (F) only for dental or vision care;
3 (G) only for hospital expenses;
4 (H) only for indemnity for hospital
5 confinement; or
6 (I) pursuant to Title XXI of the
7 Social Security Act (42 U.S.C. Section 1397aa et
8 seq.);
9 (2) a Medicare supplemental policy as
10 defined by Section 1882(g)(1), Social Security Act (42
11 U.S.C. Section 1395ss), as amended;
12 (3) a workers' compensation insurance
13 policy;
14 (4) medical payment insurance coverage
15 provided under a motor vehicle insurance policy; or
16 (5) a long-term care insurance policy,
17 including a nursing home fixed indemnity policy,
18 unless the commissioner determines that the policy
19 provides benefit coverage so comprehensive that the
20 policy is a health benefit plan as described by
21 Subsection (a) of this section.

22 Revised Law

23 Sec. 1206.003. DENIAL OF ENROLLMENT PROHIBITED. A health
24 benefit plan issuer may not refuse to enroll an individual in the
25 plan solely because the individual is enrolled in another health
26 benefit plan at the time the individual applies for coverage under
27 the plan. (V.T.I.C. Art. 21.52L, Sec. 2, as added Acts 77th Leg.,
28 R.S., Ch. 1074.)

29 Source Law

30 Sec. 2. The issuer of a health benefit plan may
31 not refuse to enroll a person in the plan solely
32 because the person is enrolled in another health
33 benefit plan at the time the person applies for the
34 coverage.

35 Revised Law

36 Sec. 1206.004. VIOLATION OF CHAPTER: UNFAIR
37 DISCRIMINATION. A health benefit plan issuer who violates this
38 chapter engages in unfair discrimination under Subchapter B,
39 Chapter 544. (V.T.I.C. Art. 21.52L, Sec. 3, as added Acts 77th
40 Leg., R.S., Ch. 1074.)

41 Source Law

42 Sec. 3. An issuer of a health benefit plan who
43 violates the article engages in unfair discrimination
44 under Article 21.21-8 of this code.

45 CHAPTER 1207. ENROLLMENT OF MEDICAL ASSISTANCE RECIPIENTS
46 AND CHILDREN ELIGIBLE FOR STATE CHILD HEALTH PLAN

47 Sec. 1207.001. APPLICABILITY OF CHAPTER 666

1 Sec. 1207.002. ENROLLMENT REQUIRED 667
2 Sec. 1207.003. EFFECTIVE DATE OF ENROLLMENT 668
3 Sec. 1207.004. TERMINATION OF ENROLLMENT 669

4 CHAPTER 1207. ENROLLMENT OF MEDICAL ASSISTANCE RECIPIENTS
5 AND CHILDREN ELIGIBLE FOR STATE CHILD HEALTH PLAN

6 Revised Law

7 Sec. 1207.001. APPLICABILITY OF CHAPTER. This chapter
8 applies only to a group health benefit plan, including a small
9 employer health benefit plan written under Chapter 1501 or a plan
10 provided under Chapter 1551, 1575, or 1601, or a successor to a plan
11 provided under one of those chapters, that provides benefits for
12 medical or surgical expenses incurred as a result of a health
13 condition, accident, or sickness, including a group, blanket, or
14 franchise insurance policy or insurance agreement, a group hospital
15 service contract, or a group evidence of coverage or similar group
16 coverage document that is offered by:

- 17 (1) an insurance company;
- 18 (2) a group hospital service corporation operating
19 under Chapter 842;
- 20 (3) a fraternal benefit society operating under
21 Chapter 885;
- 22 (4) a stipulated premium company operating under
23 Chapter 884;
- 24 (5) a reciprocal exchange operating under Chapter 942;
- 25 (6) a health maintenance organization operating under
26 Chapter 843;
- 27 (7) a multiple employer welfare arrangement that holds
28 a certificate of authority under Chapter 846; or
- 29 (8) an approved nonprofit health corporation that
30 holds a certificate of authority under Chapter 844. (V.T.I.C. Art.
31 21.52K, Sec. 1.)

32 Source Law

33 Art. 21.52K
34 Sec. 1. (a) In this article, "group health
35 benefit plan" means a plan that provides benefits for

1 medical or surgical expenses incurred as a result of a
2 health condition, accident, or sickness, including a
3 group, blanket, or franchise insurance policy or
4 insurance agreement, a group hospital service
5 contract, or a group evidence of coverage or similar
6 group coverage document that is offered by:

- 7 (1) an insurance company;
- 8 (2) a group hospital service corporation
9 operating under Chapter 20 of this code;
- 10 (3) a fraternal benefit society operating
11 under Chapter 10 of this code;
- 12 (4) a stipulated premium insurance company
13 operating under Chapter 22 of this code;
- 14 (5) a reciprocal exchange operating under
15 Chapter 19 of this code;
- 16 (6) a health maintenance organization
17 operating under the Texas Health Maintenance
18 Organization Act (Chapter 20A, Vernon's Texas
19 Insurance Code);
- 20 (7) a multiple employer welfare
21 arrangement that holds a certificate of authority
22 under Article 3.95-2 of this code; or
- 23 (8) an approved nonprofit health
24 corporation that holds a certificate of authority
25 under Article 21.52F of this code.

26 (b) The term "group health benefit plan"
27 includes:

- 28 (1) a small employer health benefit plan
29 written under Chapter 26 of this code; and
- 30 (2) a plan provided under the Texas
31 Employees Uniform Group Insurance Benefits Act
32 (Article 3.50-2, Vernon's Texas Insurance Code), the
33 Texas State College and University Employees Uniform
34 Insurance Benefits Act (Article 3.50-3, Vernon's Texas
35 Insurance Code), the Texas Public School Employees
36 Group Insurance Act (Article 3.50-4, Vernon's Texas
37 Insurance Code), or a successor of any of those plans.

38 Revised Law

39 Sec. 1207.002. ENROLLMENT REQUIRED. (a) A group health
40 benefit plan issuer shall permit an individual who is otherwise
41 eligible for enrollment in the plan to enroll in the plan, without
42 regard to any enrollment period restriction, on receipt of written
43 notice from the Texas Department of Health or a designee of that
44 department stating that the individual is:

45 (1) a recipient of medical assistance under the state
46 Medicaid program and is a participant in the health insurance
47 premium payment reimbursement program under Section 32.0422, Human
48 Resources Code; or

49 (2) a child enrolled in the state child health plan
50 under Chapter 62, Health and Safety Code, and is a participant in
51 the health insurance premium payment reimbursement program under
52 Section 62.059, Health and Safety Code.

1 (b) If an individual described by Subsection (a)(1) or (2)
2 is not eligible to enroll in the group health benefit plan unless a
3 family member of the individual is also enrolled in the plan, the
4 plan issuer, on receipt of written notice under Subsection (a),
5 shall enroll both the individual and the family member in the plan.
6 (V.T.I.C. Art. 21.52K, Secs. 2(a), (b), (c).)

7 Source Law

8 Sec. 2. (a) The issuer of a group health
9 benefit plan, on receipt of written notice from the
10 Texas Department of Health or a designee of the Texas
11 Department of Health that states that an individual
12 who is otherwise eligible for enrollment in the plan is
13 a recipient of medical assistance under the state
14 Medicaid program and is a participant in the health
15 insurance premium payment reimbursement program for
16 medical assistance recipients under Section 32.0422,
17 Human Resources Code, shall permit the individual to
18 enroll in the plan without regard to any enrollment
19 period restriction.

20 (b) The issuer of a group health benefit plan,
21 on receipt of written notice from the Texas Department
22 of Health or a designee of the Texas Department of
23 Health that states that a child who is otherwise
24 eligible for enrollment in the plan is enrolled in the
25 state child health plan under Chapter 62, Health and
26 Safety Code, and is a participant in the health
27 insurance premium payment reimbursement program under
28 Section 62.059, Health and Safety Code, provided for
29 children eligible for the state child health plan
30 shall permit the child to enroll in the group health
31 benefit plan without regard to any enrollment period
32 restriction.

33 (c) If an individual described by Subsection (a)
34 or (b) of this section is not eligible to enroll in the
35 plan unless a family member of the individual is also
36 enrolled in the plan, the issuer, on receipt of the
37 written notice under Subsection (a) or (b) of this
38 section, shall enroll both the individual and the
39 family member in the plan.

40 Revised Law

41 Sec. 1207.003. EFFECTIVE DATE OF ENROLLMENT. Unless
42 enrollment occurs during an established enrollment period,
43 enrollment in a group health benefit plan under Section 1207.002
44 takes effect on the first day of the calendar month that begins at
45 least 30 days after the date written notice is received by the plan
46 issuer under Section 1207.002(a). (V.T.I.C. Art. 21.52K, Sec.
47 2(d).)

48 Source Law

49 (d) Unless enrollment occurs during an
50 established enrollment period, enrollment under this

1 article takes effect on the first day of the calendar
2 month that begins at least 30 days after the date
3 written notice is received by the issuer under
4 Subsection (a) or (b) of this section.

5 Revised Law

6 Sec. 1207.004. TERMINATION OF ENROLLMENT. (a)

7 Notwithstanding any other requirement of a group health benefit
8 plan, the plan issuer shall permit an individual who is enrolled in
9 the plan under Section 1207.002(a)(1), and any family member of the
10 individual enrolled under Section 1207.002(b), to terminate
11 enrollment in the plan not later than the 60th day after the date on
12 which the individual provides satisfactory proof to the issuer that
13 the individual is no longer:

14 (1) a recipient of medical assistance under the state
15 Medicaid program; or

16 (2) a participant in the health insurance premium
17 payment reimbursement program under Section 32.0422, Human
18 Resources Code.

19 (b) Notwithstanding any other requirement of a group health
20 benefit plan, the plan issuer shall permit an individual who is
21 enrolled in the plan under Section 1207.002(a)(2), and any family
22 member of the individual enrolled under Section 1207.002(b), to
23 terminate enrollment in the plan not later than the 60th day after
24 the date on which the individual provides satisfactory proof to the
25 issuer that the child is no longer a participant in the health
26 insurance premium payment reimbursement program under Section
27 62.059, Health and Safety Code. (V.T.I.C. Art. 21.52K, Secs. 2(e),
28 (f).)

29 Source Law

30 (e) Notwithstanding any other requirement of
31 the group health benefit plan, the issuer of the plan
32 shall permit an individual who is enrolled in a group
33 health benefit plan under Subsection (a) of this
34 section, and any family member of the individual
35 enrolled under Subsection (c) of this section, to
36 terminate enrollment in the plan not later than the
37 60th day after the date on which the individual
38 provides satisfactory proof to the issuer that the
39 individual is no longer:

40 (1) a recipient of medical assistance
41 under the state Medicaid program; or

42 (2) a participant in the health insurance

1 premium payment reimbursement program for medical
2 assistance recipients under Section 32.0422, Human
3 Resources Code.

4 (f) Notwithstanding any other requirement of
5 the group health benefit plan, the issuer of the plan
6 shall permit an individual who is enrolled in a group
7 health benefit plan under Subsection (b) of this
8 section, and any family member of the individual
9 enrolled under Subsection (c) of this section, to
10 terminate enrollment in the plan not later than the
11 60th day after the date on which the individual
12 provides satisfactory proof to the issuer that the
13 child is no longer a participant in the health
14 insurance premium payment reimbursement program under
15 Section 62.059, Health and Safety Code, provided for
16 children eligible for the state child health plan.

17 CHAPTER 1208. IDENTITY OF AVAILABLE EMPLOYEE OF HEALTH

18 BENEFIT PLAN ISSUER

19 Sec. 1208.001. APPLICABILITY OF CHAPTER 670

20 Sec. 1208.002. DISCLOSURE REQUIRED 671

21 CHAPTER 1208. IDENTITY OF AVAILABLE EMPLOYEE OF HEALTH

22 BENEFIT PLAN ISSUER

23 Revised Law

24 Sec. 1208.001. APPLICABILITY OF CHAPTER. This chapter
25 applies only to a health benefit plan that provides benefits for
26 medical or surgical expenses incurred as a result of a health
27 condition, accident, or sickness, including an individual, group,
28 blanket, or franchise insurance policy or insurance agreement, a
29 group hospital service contract, or an individual or group evidence
30 of coverage or similar coverage document that is offered by:

31 (1) an insurance company;

32 (2) a group hospital service corporation operating
33 under Chapter 842;

34 (3) a fraternal benefit society operating under
35 Chapter 885;

36 (4) a stipulated premium company operating under
37 Chapter 884;

38 (5) a reciprocal exchange operating under Chapter 942;

39 (6) a health maintenance organization operating under
40 Chapter 843;

41 (7) a multiple employer welfare arrangement that holds
42 a certificate of authority under Chapter 846; or

1 (8) an approved nonprofit health corporation that
2 holds a certificate of authority under Chapter 844. (V.T.I.C. Art.
3 21.24-3, Sec. 1.)

4 Source Law

5 Art. 21.24-3

6 Sec. 1. In this article, "health benefit plan"
7 means a plan that provides benefits for medical or
8 surgical expenses incurred as a result of a health
9 condition, accident, or sickness, including an
10 individual, group, blanket, or franchise insurance
11 policy or insurance agreement, a group hospital
12 service contract, or an individual or group evidence
13 of coverage or similar coverage document that is
14 offered by:

- 15 (1) an insurance company;
16 (2) a group hospital service corporation
17 operating under Chapter 20 of this code;
18 (3) a fraternal benefit society operating
19 under Chapter 10 of this code;
20 (4) a stipulated premium insurance company
21 operating under Chapter 22 of this code;
22 (5) a reciprocal exchange operating under
23 Chapter 19 of this code;
24 (6) a health maintenance organization
25 operating under the Texas Health Maintenance
26 Organization Act (Chapter 20A, Vernon's Texas
27 Insurance Code);
28 (7) a multiple employer welfare
29 arrangement that holds a certificate of authority
30 under Article 3.95-2 of this code; or
31 (8) an approved nonprofit health
32 corporation that holds a certificate of authority
33 under Article 21.52F of this code.

34 Revised Law

35 Sec. 1208.002. DISCLOSURE REQUIRED. After an oral or
36 written request by an insured or enrollee of a health benefit plan,
37 the plan issuer shall provide to the insured or enrollee the name or
38 employee identifier of the issuer's employee who is available to
39 respond to questions or other communication from the insured or
40 enrollee relating to coverage and benefits provided under the plan
41 to the insured or enrollee. The issuer shall also provide:

- 42 (1) the employee's mailing address;
43 (2) the municipality and state of the employee's
44 business location; and
45 (3) the employee's job title. (V.T.I.C. Art. 21.24-3,
46 Sec. 2.)

47 Source Law

48 Sec. 2. After an oral or written request by an

1 insured or enrollee of a health benefit plan for the
2 information, the issuer of the health benefit plan
3 shall provide to the insured or enrollee the name or
4 employee identifier, mailing address, business city
5 and state location, and job title of the employee of
6 the issuer of the health benefit plan who is available
7 to the enrollee or insured to respond to
8 communications and questions from the insured or
9 enrollee relating to coverage and benefits provided by
10 the health benefit plan to the insured or enrollee.

11 Revisor's Note

12 Section 2, V.T.I.C. Article 21.24-3, refers to
13 "city." The revised law substitutes the term
14 "municipality" for "city" because that is the term
15 used in the Local Government Code.

16 CHAPTER 1209. HEALTH BENEFIT CLAIMS COST INFORMATION

17 REQUIRED TO BE PROVIDED TO EMPLOYER

18 Sec. 1209.001. APPLICABILITY OF CHAPTER 672
19 Sec. 1209.002. CLAIMS COST INFORMATION. 673
20 Sec. 1209.003. CONFIDENTIALITY 674

21 CHAPTER 1209. HEALTH BENEFIT CLAIMS COST INFORMATION

22 REQUIRED TO BE PROVIDED TO EMPLOYER

23 Revised Law

24 Sec. 1209.001. APPLICABILITY OF CHAPTER. This chapter
25 applies only to a group health benefit plan, including a small
26 employer health benefit plan written under Chapter 1501, that:

27 (1) provides benefits for medical or surgical expenses
28 incurred as a result of a health condition, accident, or sickness,
29 including a group, blanket, or franchise insurance policy or
30 insurance agreement, a group hospital service contract, or a group
31 evidence of coverage or similar group coverage document that is
32 offered by:

- 33 (A) an insurance company;
- 34 (B) a group hospital service corporation
35 operating under Chapter 842;
- 36 (C) a fraternal benefit society operating under
37 Chapter 885;
- 38 (D) a stipulated premium company operating under
39 Chapter 884;

1 (E) a reciprocal exchange operating under
2 Chapter 942;

3 (F) a health maintenance organization operating
4 under Chapter 843;

5 (G) a multiple employer welfare arrangement that
6 holds a certificate of authority under Chapter 846; or

7 (H) an approved nonprofit health corporation
8 that holds a certificate of authority under Chapter 844; and

9 (2) provides health benefits to the employees of one
10 or more employers that sponsor the plan. (V.T.I.C. Art. 21.49-19,
11 Secs. 1, 2.)

12 Source Law

13 Art. 21.49-19

14 Sec. 1. (a) In this article, "group health
15 benefit plan" means a plan that provides benefits for
16 medical or surgical expenses incurred as a result of a
17 health condition, accident, or sickness, including a
18 group, blanket, or franchise insurance policy or
19 insurance agreement, a group hospital service
20 contract, or a group evidence of coverage or similar
21 group coverage document that is offered by:

22 (1) an insurance company;

23 (2) a group hospital service corporation
24 operating under Chapter 20 of this code;

25 (3) a fraternal benefit society operating
26 under Chapter 10 of this code;

27 (4) a stipulated premium insurance company
28 operating under Chapter 22 of this code;

29 (5) a reciprocal exchange operating under
30 Chapter 19 of this code;

31 (6) a health maintenance organization
32 operating under the Texas Health Maintenance
33 Organization Act (Chapter 20A, Vernon's Texas
34 Insurance Code);

35 (7) a multiple employer welfare
36 arrangement that holds a certificate of authority
37 under Article 3.95-2 of this code; or

38 (8) an approved nonprofit health
39 corporation that holds a certificate of authority
40 under Article 21.52F of this code.

41 (b) The term "group health benefit plan"
42 includes a small employer health benefit plan written
43 under Chapter 26 of this code.

44 Sec. 2. This article applies only to a group
45 health benefit plan issued to provide health benefits
46 to the employees of one or more employers that sponsor
47 the plan.

48 Revised Law

49 Sec. 1209.002. CLAIMS COST INFORMATION. (a) On the
50 request of an employer sponsoring a group health benefit plan, the
51 plan issuer shall provide to the employer the claims cost

1 information for employees covered by the plan during the preceding
2 calendar year.

3 (b) Claims cost information provided under this section:

4 (1) may be provided in the aggregate or on a detailed
5 basis;

6 (2) must be provided separately for each month during
7 which the group health benefit plan was in effect; and

8 (3) may not include information, including diagnosis
9 code information, that may be used to identify a specific
10 individual enrolled in the plan or a diagnosis of that individual.

11 (V.T.I.C. Art. 21.49-19, Secs. 3(a), (b).)

12 Source Law

13 Sec. 3. (a) On the request of an employer
14 sponsoring a group health benefit plan, the issuer of
15 the plan shall provide to the employer the claims cost
16 information for employees covered by the plan during
17 the preceding calendar year. The information must be
18 reported separately for each month during which the
19 plan was in effect.

20 (b) Claims cost information provided under this
21 section may be provided either in the aggregate or on a
22 detailed basis, but may not include:

23 (1) any information through which a
24 specific individual enrolled in the group health
25 benefit plan may be identified; or

26 (2) diagnosis codes or other information
27 through which a diagnosis of a specific individual
28 enrolled in the group health benefit plan may be
29 identified.

30 Revised Law

31 Sec. 1209.003. CONFIDENTIALITY. Information obtained by
32 an employer under this chapter is confidential and may be used by
33 the employer only for purposes relating to obtaining or maintaining
34 group health benefit plan coverage for the employer's employees.

35 (V.T.I.C. Art. 21.49-19, Sec. 3(c).)

36 Source Law

37 (c) Information obtained by the employer under
38 this section is confidential and may be used by the
39 employer only for purposes relating to obtaining and
40 maintaining group health benefit plan coverage for the
41 employer's employees.

42 CHAPTER 1210. NOTICE OF CERTAIN POLICY PROVISIONS

43 Sec. 1210.001. NOTICE REQUIRED 675

1 CHAPTER 1210. NOTICE OF CERTAIN POLICY PROVISIONS

2 Revised Law

3 Sec. 1210.001. NOTICE REQUIRED. A policy, contract, or
4 certificate of insurance that insures against loss resulting from
5 sickness or accidental bodily injury and that is subject to an
6 increase in the premium at time of renewal or to nonrenewal on the
7 insured attaining a certain age may not be delivered, issued, or
8 used in this state unless the document contains on the first page
9 above the policy provisions a printed notice in 10-point type that
10 states that the policy, contract, or certificate is subject to
11 either or both conditions. (V.T.I.C. Art. 3.42-1, Secs. (a), (b).)

12 Source Law

13 Art. 3.42-1. (a) As used in this article,
14 "health insurance policy" means a policy, contract, or
15 certificate of insurance which insures against loss
16 resulting from sickness or accidental bodily injury.

17 (b) No health insurance policy which is subject
18 to an increase in the premium at time of renewal, which
19 is subject to nonrenewal on the insured attaining a
20 certain age, or which is subject to both of these
21 conditions and limitations, may be delivered, issued,
22 or used in this state unless there is printed, above
23 the first of the policy provisions on the first page in
24 10-point type, notice that the policy is subject to any
25 or all of the conditions stated in this section.

26 Revisor's Note

27 Section (c), V.T.I.C. Article 3.42-1, refers to
28 the notice required of certain policy forms used
29 before June 1, 1974. That part of the law is executed
30 and therefore is omitted from the revised law. The
31 omitted law reads:

32 (c) Until June 1, 1974, any company
33 may continue to use any policy form
34 heretofore approved for issuance by the
35 State Board of Insurance by either (i)
36 stamping or affixing such language at the
37 top of the first policy page or (ii)
38 affixing an endorsement containing such
39 required language at the top of the first
40 page of each such policy form, either of
41 which shall be at least in 10-point type.

42 [Chapters 1211-1250 reserved for expansion]

1 SUBTITLE B. GROUP HEALTH COVERAGE

2 CHAPTER 1251. GROUP AND BLANKET HEALTH INSURANCE

3 SUBCHAPTER A. GENERAL PROVISIONS

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17		SUBCHAPTER A. GENERAL PROVISIONS	
18		<u>Revised Law</u>	
19	Sec. 1251.001.	DEFINITIONS. In this chapter:	
20		(1) "Blanket accident and health insurance" means	
21		accident, health, or accident and health insurance covering a group	
22		described by Subchapter H.	
23		(2) "Group accident and health insurance" means	
24		accident, health, or accident and health insurance covering a group	
25		described by Subchapter B.	
26		(3) "Group hospital service corporation" means a	
27		corporation operating under Chapter 842. (V.T.I.C. Art. 3.51-6,	
28		Secs. 1(a) (part), 2(a) (part).)	
29		<u>Source Law</u>	
30		Art. 3.51-6	
31		Sec. 1. (a) Group accident and health	
32		insurance is hereby defined to be that form of	
33		accident, sickness, or accident and sickness insurance	
34		covering groups of persons as provided in Subdivisions	
35		(1) through (6) below:	
36		.	
37		Sec. 2. (a) Blanket accident and health	
38		insurance is hereby defined to be that form of	

1 accident, health, or accident and health insurance
2 covering groups of persons as provided in (1) through
3 (9) below:

4 . . .

5 Revisor's Note

6 (1) Section 1(a), V.T.I.C. Article 3.51-6,
7 defines group accident and health insurance as
8 "accident, sickness, or accident and sickness
9 insurance." For consistency throughout this chapter,
10 the revised law substitutes "health insurance" for
11 "sickness insurance."

12 (2) The definition of "group hospital service
13 corporation" is added to the revised law for drafting
14 convenience and to eliminate frequent, unnecessary
15 repetition of the substance of the definition.
16 Throughout this chapter, the revised law substitutes
17 the defined term for the substance of the definition.

18 Revised Law

19 Sec. 1251.002. CERTAIN GROUP HEALTH INSURANCE
20 AUTHORIZED. A group policy of accident, health, or accident and
21 health insurance, including a group contract issued by a group
22 hospital service corporation, may be delivered or issued for
23 delivery in this state only if the policy:

24 (1) covers a group described by Subchapter B; and

25 (2) meets the requirements adopted under this chapter
26 for a group policy. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(1).)

27 Source Law

28 (d)(1) No group policy of accident, health, or
29 accident and health insurance, including group
30 contracts issued by companies subject to Chapter 20,
31 Insurance Code, as amended, shall be delivered or
32 issued for delivery in this state which does not
33 conform to the requirements and definitions set forth
34 in Subdivisions (a)(1) through (a)(6) of this section.

35 Revisor's Note

36 Section 1(d)(1), V.T.I.C. Article 3.51-6, refers
37 to "Chapter 20, Insurance Code, as amended." The
38 revised law omits the reference to "as amended"
39 because Section 311.027, Government Code (Code

1 Construction Act), applicable to the revised law,
2 provides that unless expressly provided otherwise, a
3 reference to any portion of a statute applies to all
4 reenactments, revisions, or amendments of the statute.

5 Revised Law

6 Sec. 1251.003. CERTAIN BLANKET HEALTH INSURANCE
7 AUTHORIZED. A blanket policy of accident, health, or accident and
8 health insurance may be delivered or issued for delivery in this
9 state only if the policy:

- 10 (1) covers a group described by Subchapter H; and
11 (2) meets the requirements adopted under this chapter
12 for a blanket policy. (V.T.I.C. Art. 3.51-6, Sec. 2(d).)

13 Source Law

14 (d) No blanket policy shall be delivered or
15 issued for delivery in this state which does not
16 conform to the requirements and definitions set forth
17 in Subdivisions (a)(1) through (a)(9) of this section.

18 Revised Law

19 Sec. 1251.004. CERTAIN PAYMENTS BY INSURERS PROHIBITED.
20 (a) Except as reimbursement for the cost of services that otherwise
21 would have been provided by the insurer, an insurer may not pay to
22 any individual, firm, corporation, or group entity a fee or
23 allowance for services related to:

- 24 (1) a group accident and health insurance policy; or
25 (2) a blanket accident and health insurance policy.
26 (b) Subsection (a) does not limit an insurer's right to:
27 (1) pay dividends;
28 (2) return a premium to a group or a combination of
29 groups;
30 (3) provide for a rate stabilization fund with
31 combinations of groups; or
32 (4) pay compensation, including a commission, to a
33 licensed agent. (V.T.I.C. Art. 3.51-6, Secs. 1(e), 2(e).)

34 Source Law

35 [Sec. 1]

36 (e) No insurer shall pay to any individual,

1 firm, corporation, or group entity any fees or
2 allowances for services related to group policies
3 except as reimbursement for the cost of such services
4 which would otherwise have been provided by the
5 insurer, provided that this provision shall not limit
6 the right of the insurer to pay dividends or make
7 returns of premium to any group or to any combination
8 of groups or make provision for rate stabilization
9 funds with combinations of groups, nor shall it
10 prohibit payment of commissions or compensation to a
11 duly licensed agent.

12 [Sec. 2]

13 (e) No insurer shall pay to any individual,
14 firm, or corporation any fees or allowances for
15 services related to blanket policies except as
16 reimbursement for the cost of such services which
17 would otherwise have been provided by the insurer
18 provided that this provision shall not limit the right
19 of the insurer to pay dividends or make return of
20 premium to any group or any combination of groups or
21 make provision for rate stabilization funds with
22 combinations of groups, nor shall it prohibit the
23 payment of commissions or compensation to a duly
24 licensed agent.

25 Revised Law

26 Sec. 1251.005. PAYMENT OF BENEFITS. (a) Except as
27 otherwise provided by this section or Section 1251.113, benefits
28 under a group accident and health insurance policy or blanket
29 accident and health insurance policy must be paid to:

- 30 (1) the insured;
- 31 (2) the insured's designated beneficiary;
- 32 (3) the insured's estate; or
- 33 (4) if the insured is a minor or is otherwise not
34 competent to give a valid release, the insured's parent, guardian,
35 or other person actually supporting the insured.

36 (b) A group accident and health insurance policy or blanket
37 accident and health insurance policy may provide that all or a
38 portion of any indemnity provided by the policy because of
39 hospital, nursing, medical, or surgical services may, at the option
40 of the insurer and unless the insured requests otherwise in writing
41 not later than the time of filing a proof of the loss, be paid
42 directly to the hospital or person providing the services. A
43 payment made as provided by this subsection discharges the
44 obligation of the insurer with respect to the amount paid.

45 (c) A group accident and health insurance policy or blanket

1 accident and health insurance policy must provide that all or a
2 portion of any benefits provided by the policy for dental care
3 services may, at the option of the insured, be assigned to the
4 dentist providing the services. In the case of an assignment under
5 this subsection, payment must be made directly to the dentist
6 designated. A payment made pursuant to an assignment under this
7 subsection discharges the obligation of the insurer with respect to
8 the amount paid. (V.T.I.C. Art. 3.51-6, Sec. 3 (part).)

9 Source Law

10 Sec. 3. Except as otherwise provided in this
11 section, all benefits under any group or blanket
12 accident and sickness policy shall be payable to the
13 person insured, or to his designated beneficiary or
14 beneficiaries, or to his estate, except that if the
15 person insured be a minor or otherwise not competent to
16 give a valid release, such benefits may be made payable
17 to his parent, guardian, or other person actually
18 supporting him. The policy may provide that all or a
19 portion of any indemnities provided by any such policy
20 on account of hospital, nursing, medical, or surgical
21 services may, at the option of the insurer and unless
22 the insured requests otherwise in writing not later
23 than the time of filing proofs of such loss, be paid
24 directly to the hospital or person rendering such
25 services. Payment so made shall discharge the
26 obligation of the insurer with respect to the amount of
27 insurance so paid. The policy shall provide that all
28 or a portion of any benefits provided by any such
29 policy for dental care services may, at the option of
30 the insured, be assigned to the dentist providing such
31 services. In the case of such assignment, payment
32 shall be made directly to the dentist designated. A
33 payment made pursuant to such assignment shall
34 discharge the obligation of the insurer with respect
35 to the amount of insurance so paid. . . .

36 Revisor's Note

37 (1) Section 3, V.T.I.C. Article 3.51-6, was
38 enacted in 1975 as part of the original enactment of
39 Article 3.51-6. See Chapter 419, Acts of the 64th
40 Legislature, Regular Session, 1975. In 1985, Article
41 3.51-6 was amended by the addition of Section 1(d)(2),
42 which prescribes provisions that must be included in a
43 group accident and health insurance policy. See
44 Chapter 673, Acts of the 69th Legislature, Regular
45 Session, 1985. Among those provisions is Section
46 1(d)(2)(xi) (revised as Section 1251.114), relating to

1 payment of benefits under a group policy. The later
2 addition of Section 1(d)(2)(xi) superseded Section 3
3 to the extent of any conflict. The revised law is
4 drafted accordingly.

5 (2) Section 3, V.T.I.C. Article 3.51-6, refers
6 both to a "person insured" and an "insured." For
7 consistency throughout the code, the revised law
8 refers to an "insured." Similar changes have been made
9 throughout this chapter.

10 Revised Law

11 Sec. 1251.006. POLICY MAY NOT SPECIFY SERVICE PROVIDER. A
12 group accident and health insurance policy or blanket accident and
13 health insurance policy may not require that a covered service be
14 provided by a particular hospital or person. (V.T.I.C. Art.
15 3.51-6, Sec. 3 (part).)

16 Source Law

17 Sec. 3. . . . The policy may not require that a
18 covered service be rendered by a particular hospital
19 or person.

20 Revised Law

21 Sec. 1251.007. EXCEPTIONS. This subchapter and
22 Subchapters B-I do not apply to:

23 (1) a credit accident and health insurance policy
24 subject to Chapter 1153;

25 (2) any group specifically provided for or authorized
26 by law in existence and covered under a policy filed with the State
27 Board of Insurance before April 1, 1975;

28 (3) accident or health coverage that is incidental to
29 any form of a group automobile, casualty, property, workers'
30 compensation, or employers' liability policy approved by the
31 commissioner; or

32 (4) any policy or contract of insurance with a state
33 agency, department, or board providing health services:

34 (A) to eligible individuals under Chapter 32,
35 Human Resources Code; or

1 (B) under a state plan adopted in accordance with
2 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section
3 1397aa et seq., as amended. (V.T.I.C. Art. 3.51-6, Sec. 4.)

4 Source Law

5 Sec. 4. The provisions of this article shall not
6 be applicable to:

7 (1) credit accident and health insurance
8 policies subject to Article 3.53 of the Insurance
9 Code, as amended;

10 (2) any group specifically provided for or
11 authorized by law in existence and covered under a
12 policy filed with the State Board of Insurance prior to
13 April 1, 1975;

14 (3) accident and health coverages that are
15 incidental to any form of group automobile, casualty,
16 property, or workmen's compensation--employers'
17 liability policies promulgated or approved by the
18 State Board of Insurance;

19 (4) any policy or contract of insurance
20 with a state agency, department, or board providing
21 health services to all eligible persons under Chapter
22 32, Human Resources Code, or in accordance with 42
23 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C.
24 Section 1397aa et seq., as amended, under a state plan.

25 Revisor's Note

26 (1) Section 4(1), V.T.I.C. Article 3.51-6,
27 refers to "Article 3.53 of the Insurance Code, as
28 amended." The revised law omits "as amended" for the
29 reason stated in the revisor's note to Section
30 1251.002.

31 (2) Section 4(3), V.T.I.C. Article 3.51-6,
32 refers to the State Board of Insurance. Chapter 685,
33 Acts of the 73rd Legislature, Regular Session, 1993,
34 abolished the board and transferred its functions to
35 the commissioner of insurance and the Texas Department
36 of Insurance. Throughout this chapter, references to
37 the board have been changed appropriately.

38 Revised Law

39 Sec. 1251.008. RULES. The commissioner may adopt rules
40 necessary to administer this chapter. A rule adopted under this
41 section is subject to notice and hearing as provided by Section
42 1201.007 for a rule adopted under Chapter 1201. (V.T.I.C. Art.
43 3.51-6, Sec. 5.)

1 (d) A group accident and health insurance policy may be
2 issued to an employer or trustees of a fund established by an
3 employer to insure the employer's active and retired employees for
4 the benefit of persons other than the employer.

5 (e) The employer or the trustees of a fund established by an
6 employer are the policyholder under a policy to which this section
7 applies. (V.T.I.C. Art. 3.51-6, Sec. 1(a) (part).)

8 Source Law

9 [(a) Group accident and health insurance is
10 hereby defined to be that form of accident, sickness,
11 or accident and sickness insurance covering groups of
12 persons as provided in Subdivisions (1) through (6)
13 below:]

14 (1) under a policy issued to an employer or
15 trustees of a fund established by an employer, who
16 shall be deemed the policyholder, insuring employees
17 of such employer for the benefit of persons other than
18 the employer. The term "employees" as used herein
19 shall be deemed to include the officers, managers, and
20 employees of the employer, the individual proprietor,
21 or partner if the employer is an individual proprietor
22 or partnership, the officers, managers, and employees
23 of subsidiary or affiliated corporations, the
24 individual proprietors, partners, and employees of
25 individuals and firms, if the business of the employer
26 and such individual or firm is under common control
27 through stock ownership, contract, or otherwise, and
28 retired employees. A policy issued to insure
29 employees of a public body may provide that the term
30 "employees" shall include elected or appointed
31 officials. The policy may provide that the term
32 "employees" shall include the trustees or their
33 employees, or both, if their duties are principally
34 connected with such trusteeship;

35 . . .

36 Revised Law

37 Sec. 1251.052. ASSOCIATIONS. (a) A group accident and
38 health insurance policy may be issued to an association, including
39 a labor union or an organization of labor unions, a membership
40 corporation organized or holding a certificate of authority under
41 the Texas Non-Profit Corporation Act (Article 1396-1.01 et seq.,
42 Vernon's Texas Civil Statutes), and a cooperative or corporation
43 subject to the supervision and control of the Farm Credit
44 Administration, to insure the association's active and retired
45 members, employees, or employees of members for the benefit of
46 persons other than the association or its officers or trustees.

47 (b) To be eligible to obtain a group accident and health

1 insurance policy, an association must:

2 (1) have a constitution and bylaws;

3 (2) have been organized and have actively existed for
4 at least two years; and

5 (3) be maintained in good faith for purposes other
6 than that of obtaining insurance. (V.T.I.C. Art. 3.51-6, Sec. 1(a)
7 (part).)

8 Source Law

9 [(a) Group accident and health insurance is
10 hereby defined to be that form of accident, sickness,
11 or accident and sickness insurance covering groups of
12 persons as provided in Subdivisions (1) through (6)
13 below:]

14 . . .
15 (2) under a policy issued to an
16 association, including but not limited to a labor
17 union or organizations of such unions, membership
18 corporations organized or holding a certificate of
19 authority under the Texas Non-Profit Corporation Act,
20 and cooperatives and corporations subject to the
21 supervision and control of the Farm Credit
22 Administration of the United States of America, and
23 which association shall have a constitution and
24 bylaws, which has been organized and has had an active
25 existence for at least two years, and which is
26 maintained in good faith for purposes other than that
27 of obtaining insurance, to insure members, employees,
28 or employees of members (active and retired for the
29 benefit of persons other than the association or its
30 officers or trustees);

31 . . .

32 Revisor's Note

33 Section 1(a)(2), V.T.I.C. Article 3.51-6, refers
34 to associations, "including but not limited to" labor
35 unions and other specified organizations. The revised
36 law omits "but not limited to" as unnecessary because
37 Section 311.005(13), Government Code (Code
38 Construction Act), applicable to the revised law,
39 provides that "includes" and "including" are terms of
40 enlargement and not of limitation and do not create a
41 presumption that components not expressed are
42 excluded.

43 Revised Law

44 Sec. 1251.053. FUNDS ESTABLISHED BY EMPLOYERS, LABOR
45 UNIONS, OR ASSOCIATIONS. (a) A group accident and health insurance

1 policy may be issued to the trustees of a fund established by two or
2 more employers in the same or related industry, by one or more labor
3 unions, by one or more employers and one or more labor unions, or by
4 an association described by Section 1251.052 to insure the active
5 and retired employees of the employers, members of the union or
6 association, or employees of the association for the benefit of
7 persons other than the employers, union, or association.

8 (b) A policy issued to the trustees of a fund established by
9 employers or a labor union or association may provide that the term
10 "employee" includes:

11 (1) an officer or manager of the employer;

12 (2) an individual proprietor or partner, if the
13 employer is an individual proprietorship or partnership; or

14 (3) a trustee, an employee of the trustees, or both, if
15 the person's duties are principally connected with the trusteeship.

16 (c) The trustees of a fund established by employers or a
17 labor union or association are the policyholder under a policy to
18 which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 1(a)
19 (part).)

20 Source Law

21 [(a) Group accident and health insurance is
22 hereby defined to be that form of accident, sickness,
23 or accident and sickness insurance covering groups of
24 persons as provided in Subdivisions (1) through (6)
25 below:]

26 . . .
27 (3) under a policy issued to the trustees
28 of a fund established by two or more employers in the
29 same or related industry or by one or more labor unions
30 or by one or more employers and one or more labor
31 unions or by an association as defined in (2) above,
32 which trustees shall be deemed the policyholder, to
33 insure employees of the employers or members of the
34 unions or such association, or employees or members of
35 such association for the benefit of persons other than
36 the employers or the unions or such association. The
37 term "employees" as used herein may include the
38 officers, managers, and employees of the employer,
39 retired employees, and the individual proprietor or
40 partners if the employer is an individual proprietor
41 or partnership. The policy may provide that the term
42 "employees" shall include the trustees or their
43 employees, or both, if their duties are principally
44 connected with such trusteeship;

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Revised Law

Sec. 1251.054. ELIGIBILITY FOR GROUP LIFE INSURANCE. A group accident and health insurance policy may be issued to any individual or organization to which a policy of group life insurance may be issued or delivered in this state to insure any class or classes of individuals that could be insured under the group life policy. (V.T.I.C. Art. 3.51-6, Sec. 1(a) (part).)

Source Law

[(a) Group accident and health insurance is hereby defined to be that form of accident, sickness, or accident and sickness insurance covering groups of persons as provided in Subdivisions (1) through (6) below:]

. . .
(4) under a policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state to insure any class or classes of individuals that could be insured under such group life policy;

. . .

Revised Law

Sec. 1251.055. FUND FOR FORMER EMPLOYEES AND MEMBERS. (a) An insurer may issue a group accident and health insurance policy to a trustee of a fund to insure former employees, former members, and the spouses, former spouses, and dependents of former employees and members who were previously insured by the insurer under a policy issued to any entity described by this subchapter.

(b) The trustee of a fund is the policyholder under a policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 1(a) (part).)

Source Law

[(a) Group accident and health insurance is hereby defined to be that form of accident, sickness, or accident and sickness insurance covering groups of persons as provided in Subdivisions (1) through (6) below:]

. . .
(5) under a policy issued by an insurer to a trustee of a fund, which shall be deemed to be the policyholder, to insure former employees, former members, their spouses, former spouses, and their dependents, who were previously insured by such insurer under a policy issued to any of the groups provided for in this article;

. . .

1 Revised Law

2 Sec. 1251.056. OTHER GROUPS. (a) Under the requirements
3 prescribed by this section, a group accident and health insurance
4 policy may be issued to cover a group other than a group described
5 by Sections 1251.051-1251.055 if the commissioner determines that:

6 (1) the issuance of the policy is not contrary to the
7 best interest of the public;

8 (2) the issuance of the policy would result in
9 economies of acquisition or administration; and

10 (3) the benefits are reasonable in relation to the
11 premiums charged.

12 (b) Group accident and health insurance coverage may not be
13 offered to a group in this state by an insurer under a policy issued
14 in another state unless this state or another state having
15 requirements substantially similar to those prescribed by
16 Subsections (a)(1)-(3) has determined that those requirements have
17 been met.

18 (c) The premium for the policy must be paid from the
19 policyholder's funds, funds contributed by the covered persons, or
20 both. (V.T.I.C. Art. 3.51-6, Sec. 1(a) (part).)

21 Source Law

22 [(a) Group accident and health insurance is
23 hereby defined to be that form of accident, sickness,
24 or accident and sickness insurance covering groups of
25 persons as provided in Subdivisions (1) through (6)
26 below:]

27 . . .
28 (6) under a policy issued to cover any
29 other group subject to the following requirements:

30 (A) No such group health insurance
31 policy shall be delivered in this state unless the
32 Commissioner of Insurance finds that:

33 (i) the issuance of such group
34 policy is not contrary to the best interest of the
35 public;

36 (ii) the issuance of the group
37 policy would result in economies of acquisition or
38 administration; and

39 (iii) the benefits are
40 reasonable in relation to the premiums charged.

41 (B) No such group health insurance
42 coverage may be offered in this state by an insurer
43 under a policy issued in another state unless this
44 state or another state having requirements
45 substantially similar to those contained in
46 Subparagraphs (i), (ii), and (iii) of Paragraph (A) of

1 this subdivision has made a determination that such
2 requirements have been met.

3 (C) The premium for the policy shall
4 be paid either from the policyholder's funds or from
5 funds contributed by the covered persons, or from
6 both.

7 [Sections 1251.057-1251.100 reserved for expansion]

8 SUBCHAPTER C. GROUP ACCIDENT AND HEALTH INSURANCE: REQUIRED
9 PROVISIONS

10 Revised Law

11 Sec. 1251.101. REQUIRED PROVISIONS. (a) A group accident
12 and health insurance policy, including a group contract issued by a
13 group hospital service corporation, may not be delivered in this
14 state unless the policy contains in substance the provisions
15 prescribed by this subchapter or provisions in relation to
16 provisions prescribed by this subchapter that, in the opinion of
17 the commissioner, are:

18 (1) more favorable to the insureds under the policy;

19 or

20 (2) at least as favorable to the insureds under the
21 policy and more favorable to the policyholder.

22 (b) The standard provisions required for individual health
23 insurance policies do not apply to group health insurance policies.

24 (c) If any provision of this subchapter is wholly or partly
25 inapplicable to or inconsistent with the coverage provided by a
26 particular form of policy, the insurer, with the approval of the
27 commissioner, shall:

28 (1) omit the inapplicable provision or part from the
29 policy; or

30 (2) modify the inconsistent provision in a manner that
31 makes the provision as contained in the policy consistent with the
32 coverage provided by the policy. (V.T.I.C. Art. 3.51-6, Sec.
33 1(d)(2) (part).)

34 Source Law

35 (2) No group policy of accident, health,
36 or accident and health insurance, including group
37 contracts issued by companies subject to Chapter 20,
38 Insurance Code, as amended, shall be delivered in this
39 state unless it contains in substance the following

1 provisions or provisions which in the opinion of the
2 commissioner are more favorable to the persons insured
3 or at least as favorable to the persons insured and
4 more favorable to the policyholder; provided, however,
5 that . . . (C) the standard provisions required for
6 individual health insurance policies shall not apply
7 to group health insurance policies; and (D) if any
8 provision of this section is in whole or in part
9 inapplicable to or inconsistent with the coverage
10 provided by a particular form of policy, the insurer,
11 with the approval of the commissioner, shall omit from
12 such policy an inapplicable provision or part of a
13 provision and shall modify an inconsistent provision
14 in such manner as to make the provision as contained in
15 the policy consistent with the coverage provided by
16 the policy:
17

. . .

18 Revisor's Note

19 (1) Section 1(d)(2), V.T.I.C. Article 3.51-6,
20 refers to a "group policy of accident, health, or
21 accident and health insurance." Throughout this
22 subchapter, the revised law substitutes "group
23 accident and health insurance" for "group . . .
24 accident, health, or accident and health insurance"
25 because that is the term defined by Section 1251.001.

26 (2) Section 1(d)(2), V.T.I.C. Article 3.51-6,
27 refers to Chapter 20, Insurance Code, "as amended."
28 The revised law omits "as amended" for the reason
29 stated in the revisor's note to Section 1251.002.

30 Revised Law

31 Sec. 1251.102. PAYMENT OF PREMIUMS. A group accident and
32 health insurance policy must provide that premiums due under the
33 policy must be remitted by the premium payor as designated in the
34 policy:

35 (1) on or before the due date; or

36 (2) within any grace period specified in the policy.

37 (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

38 Source Law

39 [(2) No group policy of accident, health,
40 or accident and health insurance . . . shall be
41 delivered in this state unless it contains . . . the
42 following provisions . . . :]

43 (i) a provision that premiums due
44 under the policy shall be remitted on or before the due
45 date by the premium payors as designated in the policy
46 and within such period of grace as may be specified

1 following provisions . . . :]

2 . . .
3 (ii) a provision that the validity of
4 the policy shall not be contested except for
5 nonpayment of premiums after it has been in force for
6 two years from its date of issue and that in the
7 absence of fraud no statement made by any person
8 covered by the policy relating to his or her
9 insurability shall be used in contesting the validity
10 of the insurance with respect to which such statement
11 was made after such insurance has been in force prior
12 to the contest for a period of two years during such
13 person's lifetime nor unless it is contained in a
14 written instrument signed by him or her; provided,
15 however, that no such provision shall preclude the
16 assertion at any time of defenses based upon: (aa)
17 provisions in the policy which relate to eligibility
18 for coverage; (bb) provisions in group accident and
19 health insurance or disability insurance policies
20 which relate to overinsurance; (cc) provisions of
21 disability policies which relate to the relation of
22 earnings to insurance; or (dd) other similar
23 provisions in such policies that limit the amounts of
24 recovery from all sources to no more than 100 percent
25 of the total actual losses or expenses incurred;
26 . . .

27 Revised Law

28 Sec. 1251.104. ENTIRE CONTRACT. A group accident and
29 health insurance policy must provide that the policy and any
30 application attached to the policy constitute the entire contract
31 between the parties. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

32 Source Law

33 [(2) No group policy of accident, health,
34 or accident and health insurance . . . shall be
35 delivered in this state unless it contains . . . the
36 following provisions . . . :]

37 . . .
38 (iii) a provision that the policy and
39 any application attached shall constitute the entire
40 contract between the parties and . . . ;
41 . . .

42 Revised Law

43 Sec. 1251.105. STATEMENT MADE BY POLICYHOLDER OR
44 INSURED. A group accident and health insurance policy must provide
45 that:

46 (1) in the absence of fraud, a statement made by the
47 policyholder or an insured is considered a representation and not a
48 warranty; and

49 (2) a statement made by the policyholder or an insured
50 may not be used in any contest under the policy, unless a copy of the
51 written instrument containing the statement is or has been provided

1 to:

2 (A) the person making the statement; or

3 (B) if the statement was made by the insured and
4 the insured has died or become incapacitated, the insured's
5 beneficiary or personal representative. (V.T.I.C. Art. 3.51-6,
6 Sec. 1(d)(2) (part).)

7 Source Law

8 [(2) No group policy of accident, health,
9 or accident and health insurance . . . shall be
10 delivered in this state unless it contains . . . the
11 following provisions . . . :]

12 . . .
13 (iii) a provision . . . that in the
14 absence of fraud all statements made by the
15 policyholder or person insured shall be deemed
16 representations and not warranties, and that no such
17 statement shall be used in any contest under the
18 policy, unless a copy of the written instrument
19 containing the statement is or has been furnished to
20 such person or in the event of death or incapacity of
21 the insured person to the individual's beneficiary or
22 personal representative;
23 . . .

24 Revised Law

25 Sec. 1251.106. DISTINCTION BASED ON MARITAL STATUS
26 PROHIBITED. A group accident and health insurance policy must
27 include a provision that prohibits a distinction on the basis of the
28 marital status or lack of marital status between an insured and the
29 other parent in the determination of the dependents or the
30 beneficiaries of the insured, or both. (V.T.I.C. Art. 3.51-6, Sec.
31 1(d)(2) (part).)

32 Source Law

33 [(2) No group policy of accident, health,
34 or accident and health insurance . . . shall be
35 delivered in this state unless it contains . . . the
36 following provisions . . . :]

37 . . .
38 (xv) a provision that, in determining
39 the dependents or the beneficiaries of an insured, or
40 both, prohibits a distinction on the basis of the
41 marital status or the lack of marital status between
42 the insured and the other parent.

43 Revised Law

44 Sec. 1251.107. EVIDENCE OF INSURABILITY. A group accident
45 and health insurance policy must state the conditions, if any,
46 under which the insurer reserves the right to require an individual

1 eligible for insurance to provide evidence of individual
2 insurability satisfactory to the insurer as a condition of
3 obtaining part or all of the coverage. (V.T.I.C. Art. 3.51-6, Sec.
4 1(d)(2) (part).)

5 Source Law

6 [(2) No group policy of accident, health,
7 or accident and health insurance . . . shall be
8 delivered in this state unless it contains . . . the
9 following provisions . . . :]

10 . . .
11 (iv) a provision setting forth the
12 conditions, if any, under which the insurer reserves
13 the right to require a person eligible for insurance to
14 furnish evidence of individual insurability
15 satisfactory to the insurer as a condition to part or
16 all of the coverage;
17 . . .

18 Revised Law

19 Sec. 1251.108. EXCLUSION OR LIMITATION OF COVERAGE FOR
20 PREEXISTING CONDITIONS. (a) A group accident and health
21 insurance policy must specify the additional exclusions or
22 limitations, if any, applicable under the policy with respect to a
23 disease or physical condition of an insured, not otherwise excluded
24 from the insured's coverage by name or specific description
25 effective on the date of the insured's loss, that existed before the
26 effective date of the insured's coverage under the policy.

27 (b) An exclusion or limitation described by Subsection (a)
28 may apply only to a disease or physical condition for which the
29 insured received medical advice or treatment during the 12 months
30 before the effective date of the insured's coverage.

31 (c) An exclusion or limitation described by Subsection (a)
32 may not apply to a loss incurred or disability beginning after the
33 earlier of:

34 (1) the end of 12 consecutive months, beginning on or
35 after the effective date of the insured's coverage, during which
36 the insured has not received medical advice or treatment in
37 connection with the disease or physical condition; or

38 (2) the second anniversary of the effective date of
39 the insured's coverage.

1 (d) This section does not apply to:

2 (1) a credit accident and health insurance policy; or

3 (2) a group accident and health insurance policy
4 subject to Chapter 1501. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2)
5 (part).)

6 Source Law

7 [(2) No group policy of accident, health,
8 or accident and health insurance . . . shall be
9 delivered in this state unless it contains . . . the
10 following provisions . . . provided, however, that]
11 (A) provisions (v), . . . shall not apply to policies
12 issued to a creditor to insure debtors of such
13 creditor; . . . :

14 . . .
15 (v) a provision specifying the
16 additional exclusions or limitations, if any,
17 applicable under the policy with respect to a disease
18 or physical condition of a person, not otherwise
19 excluded from the person's coverage by name or specific
20 description effective on the date of the person's loss,
21 which existed prior to the effective date of the
22 person's coverage under the policy. Any such exclusion
23 or limitation may only apply to a disease or physical
24 condition for which medical advice or treatment was
25 received by the person during the 12 months prior to
26 the effective date of the person's coverage. In no
27 event shall such exclusion or limitation apply to loss
28 incurred or disability commencing after the earlier
29 of: (aa) the end of a continuous period of 12 months
30 commencing on or after the effective date of the
31 person's coverage during all of which the person has
32 received no medical advice or treatment in connection
33 with such disease or physical condition; and (bb) the
34 end of the two-year period commencing on the effective
35 date of the person's coverage;

36 . . .

37 Revisor's Note

38 Section 1(d)(2), V.T.I.C. Article 3.51-6,
39 prescribes certain requirements applicable to
40 exclusions or limitations on preexisting conditions
41 under a group accident and health insurance policy.
42 The revised law clarifies that these requirements do
43 not apply to group accident and health insurance
44 policies subject to V.T.I.C. Chapter 26, revised in
45 this code as Chapter 1501, because the later-enacted
46 preexisting condition requirements in Chapter 26
47 supersede the preexisting condition requirements in
48 Article 3.51-6 with respect to group policies subject

1 to Chapter 26.

2 Revised Law

3 Sec. 1251.109. ADJUSTMENT OF PREMIUMS OR BENEFITS IF AGE OF
4 INSURED IS MISSTATED. (a) A group accident and health insurance
5 policy under which the premiums or benefits vary by age must specify
6 an equitable adjustment of premiums or benefits, or both, to be made
7 if the age of an insured has been misstated.

8 (b) The provision required by Subsection (a) must contain a
9 clear statement of the method of adjustment to be used. (V.T.I.C.
10 Art. 3.51-6, Sec. 1(d)(2) (part).)

11 Source Law

12 [(2) No group policy of accident, health,
13 or accident and health insurance . . . shall be
14 delivered in this state unless it contains . . . the
15 following provisions . . . :]

16 . . .
17 (vi) if the premiums or benefits vary
18 by age, a provision specifying an equitable adjustment
19 of premiums or of benefits, or both, to be made in the
20 event the age of a covered person has been misstated,
21 such provision to contain a clear statement of the
22 method of adjustment to be used;

23 . . .

24 Revised Law

25 Sec. 1251.110. DEADLINE FOR NOTICE OF CLAIM. (a) A group
26 accident and health insurance policy must provide that written
27 notice of a claim must be given to the insurer not later than the
28 20th day after the date of the occurrence or beginning of any loss
29 covered by the policy.

30 (b) Failure to give notice within the time prescribed by
31 Subsection (a) does not invalidate or reduce any claim if it is
32 shown that:

33 (1) it was not reasonably possible to give the notice
34 within that time; and

35 (2) notice was given as soon as was reasonably
36 possible. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

37 Source Law

38 [(2) No group policy of accident, health,
39 or accident and health insurance . . . shall be
40 delivered in this state unless it contains . . . the
41 following provisions . . . :]

1 for a loss of time for disability, written proof of the loss must be
2 provided to the insurer not later than the 90th day after the date
3 of the loss; and

4 (2) in the case of a claim for loss of time for
5 disability:

6 (A) written proof of the loss must be provided to
7 the insurer not later than the 90th day after the beginning of the
8 period for which the insurer is liable; and

9 (B) subsequent written proofs of the continuance
10 of the disability must be provided to the insurer at intervals as
11 reasonably required by the insurer.

12 (b) Failure to provide written proof of a loss within the
13 time prescribed by Subsection (a) does not invalidate or reduce a
14 claim if:

15 (1) it was not reasonably possible to provide written
16 proof of the loss within that time;

17 (2) written proof of the loss is provided as soon as
18 reasonably possible; and

19 (3) unless the claimant does not have the legal
20 capacity to provide proof of loss, proof of loss is provided not
21 later than the first anniversary of the date the proof of loss is
22 otherwise required. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

23 Source Law

24 [(2) No group policy of accident, health,
25 or accident and health insurance . . . shall be
26 delivered in this state unless it contains . . . the
27 following provisions . . . :]

28 . . .
29 (ix) a provision that in the case of
30 claim for loss of time for disability, written proof of
31 such loss must be furnished to the insurer within the
32 90 days after the commencement of the period for which
33 the insurer is liable, that subsequent written proofs
34 of the continuance of such disability must be
35 furnished to the insurer at such intervals as the
36 insurer may reasonably require, and that in the case of
37 claim for any other loss written proof of such loss
38 must be furnished to the insurer within 90 days after
39 the date of such loss. Failure to furnish such proof
40 within such time shall not invalidate or reduce any
41 claim if it was not reasonably possible to furnish such
42 proof within such time, provided such proof is
43 furnished as soon as reasonably possible and in no
44 event, except in the absence of legal capacity of the

1 claimant, later than one year from the time proof is
2 otherwise required;

3 . . .

4 Revised Law

5 Sec. 1251.113. PROMPT PAYMENT OF BENEFITS REQUIRED. A
6 group accident and health insurance policy must provide that:

7 (1) all benefits payable under the policy, other than
8 benefits for loss of time, must be paid not later than the 60th day
9 after the date the proof of loss is received; and

10 (2) subject to written proof of loss, all accrued
11 benefits payable under the policy for loss of time must be paid at
12 least monthly during the period for which the insurer is liable, and
13 that any balance remaining unpaid at the end of that period must be
14 paid as soon as possible after the proof of loss is received.

15 (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

16 Source Law

17 [(2) No group policy of accident, health,
18 or accident and health insurance . . . shall be
19 delivered in this state unless it contains . . . the
20 following provisions . . . :]

21 . . .

22 (x) a provision that all benefits
23 payable under the policy other than benefits for loss
24 of time shall be payable not more than 60 days after
25 receipt of proof, that, subject to due proof of loss,
26 all accrued benefits payable under the policy for loss
27 of time shall be paid not less frequently than monthly
28 during the continuance of the period for which the
29 insurer is liable, and that any balance remaining
30 unpaid at the termination of such period shall be paid
31 as soon as possible after receipt of such proof;

32 . . .

33 Revised Law

34 Sec. 1251.114. PAYMENT OF BENEFITS. (a) A group accident
35 and health insurance policy must provide that all benefits of the
36 policy, other than benefits for loss of life, must be paid to the
37 insured or the insured's assignee.

38 (b) A group accident and health insurance policy must
39 provide that, subject to the provisions of the policy, benefits for
40 loss of life of an insured must be paid to:

41 (1) the beneficiary designated by the insured or the
42 beneficiary's assignee;

43 (2) the family member specified by the policy terms,

1 if the policy contains conditions relating to family status; or

2 (3) the estate of the insured, if the designated or
3 specified beneficiary is not living at the time the insured dies.

4 (c) A group accident and health insurance policy may provide
5 that if any benefits are payable to the estate of an individual or
6 to an individual who is a minor or is otherwise not competent to
7 give a valid release, the insurer may pay the benefits, up to an
8 amount established by the commissioner, to any individual related
9 by consanguinity or affinity to the individual who is considered by
10 the insurer to be equitably entitled to the benefits.

11 (d) This section does not apply to:

12 (1) a credit accident and health insurance policy; or

13 (2) a group contract issued by a group hospital
14 service corporation. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

15 Source Law

16 [(2) No group policy of accident, health,
17 or accident and health insurance . . . shall be
18 delivered in this state unless it contains . . . the
19 following provisions . . . provided, however, that (A)
20 provisions . . .] (xi), and . . . shall not apply to
21 policies issued to a creditor to insure debtors of such
22 creditor; (B) provision (xi) shall not apply to
23 Chapter 20 companies; . . . :

24 . . .
25 (xi) a provision that benefits for
26 loss of life of the person insured shall be payable to
27 the beneficiary designated by the person insured or
28 the assignee. However, if the policy contains
29 conditions pertaining to family status the beneficiary
30 may be the family member specified by the policy terms.
31 In either case, payment of these benefits is subject to
32 the provisions of the policy. In the event no such
33 designated or specified beneficiary is living at the
34 death of the person insured, the benefits shall be
35 payable to the estate of the insured. All other
36 benefits of the policy shall be payable to the person
37 insured or the assignee. The policy may also provide
38 that if any benefit is payable to the estate of a
39 person or to a person who is a minor or otherwise not
40 competent to give a valid release, the insurer may pay
41 such benefit, up to an amount established by the board,
42 to any relative by blood or connection by marriage of
43 such person who is deemed by the insurer to be
44 equitably entitled thereto;
45 . . .

46 Revised Law

47 Sec. 1251.115. RIGHT TO CONDUCT PHYSICAL EXAMINATION OR
48 AUTOPSY. A group accident and health insurance policy must provide

1 that the insurer has the right and opportunity to:

2 (1) conduct a physical examination of an individual
3 for whom a claim is made when and as often as the insurer reasonably
4 requires during the pendency of the claim under the policy; and

5 (2) in the case of a death, require that an autopsy be
6 conducted, unless the autopsy is prohibited by law. (V.T.I.C. Art.
7 3.51-6, Sec. 1(d)(2) (part).)

8 Source Law

9 [(2) No group policy of accident, health,
10 or accident and health insurance . . . shall be
11 delivered in this state unless it contains . . . the
12 following provisions . . . :]

13 . . .
14 (xii) a provision that the insurer
15 shall have the right and opportunity to examine the
16 person of the individual for whom claim is made when
17 and so often as it may reasonably require during the
18 pendency of claim under the policy and also the right
19 and opportunity to make an autopsy in case of death
20 where it is not prohibited by law;
21 . . .

22 Revised Law

23 Sec. 1251.116. LEGAL OR EQUITABLE ACTIONS; LIMITATIONS. A
24 group accident and health insurance policy must provide that an
25 action at law or in equity may not be brought to recover on the
26 policy:

27 (1) before the 61st day after the date written proof of
28 loss is filed as required under the policy; or

29 (2) after the third anniversary of the date on which
30 written proof of loss is required under the policy to be filed.
31 (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2) (part).)

32 Source Law

33 [(2) No group policy of accident, health,
34 or accident and health insurance . . . shall be
35 delivered in this state unless it contains . . . the
36 following provisions . . . :]

37 . . .
38 (xiii) a provision that no action at
39 law or in equity shall be brought to recover on the
40 policy prior to the expiration of 60 days after proof
41 of loss has been filed in accordance with the
42 requirements of the policy and that no such action
43 shall be brought at all unless brought within three
44 years from the expiration of the time within which
45 proof of loss is required by the policy;
46 . . .

1 Revised Law

2 Sec. 1251.117. CONTINUATION OR CONVERSION OF COVERAGE. (a)
3 A group accident and health insurance policy must describe the
4 continuation of group coverage and any conversion coverage provided
5 in accordance with Subchapter F.

6 (b) Subsection (a) does not apply to a credit accident and
7 health insurance policy. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(2)
8 (part).)

9 Source Law

10 [(2) No group policy of accident, health,
11 or accident and health insurance . . . shall be
12 delivered in this state unless it contains . . . the
13 following provisions . . . provided, however, that
14 (A) provisions . . .] (xiv) shall not apply to
15 policies issued to a creditor to insure debtors of such
16 creditor; . . . :

17 . . .
18 (xiv) a provision describing the
19 conversion or extension of coverage option elected by
20 the insurer in accordance with Subdivision (3) of
21 Subsection (d) of this section; and
22 . . .

23 Revisor's Note

24 Section 1(d)(2)(xiv), V.T.I.C. Article 3.51-6,
25 refers to "the conversion or extension of coverage
26 option elected by the insurer in accordance with
27 Subdivision (3) of Subsection (d)" (revised as
28 Subchapter F). Article 3.51-6 was amended by Chapter
29 673, Acts of the 69th Legislature, Regular Session,
30 1985; those amendments included the addition of
31 Sections 1(d)(2) and (3). As enacted in 1985, Section
32 1(d)(3) required an insurer to provide either a
33 "conversion or group continuation privilege." Section
34 1(d)(3) was amended by Chapter 837, Acts of the 75th
35 Legislature, Regular Session, 1997. Under the 1997
36 amendments, an insurer must provide a continuation
37 privilege and may provide conversion coverage. The
38 later amendment of Section 1(d)(3) supersedes Section
39 1(d)(2)(xiv). The revised law is drafted accordingly.

40 [Sections 1251.118-1251.150 reserved for expansion]

1 SUBCHAPTER D. GROUP ACCIDENT AND HEALTH INSURANCE:

2 COVERAGE FOR DEPENDENTS

3 Revised Law

4 Sec. 1251.151. COVERAGE FOR CERTAIN GRANDCHILDREN. (a) A
5 group policy or contract of insurance for hospital, surgical, or
6 medical expenses incurred as a result of accident or sickness,
7 including a group contract issued by a group hospital service
8 corporation, that provides coverage under the policy or contract
9 for a child of an insured must, on payment of a premium, provide
10 coverage for any grandchild of the insured if the grandchild is:

11 (1) unmarried;

12 (2) younger than 25 years of age; and

13 (3) a dependent of the insured for federal income tax
14 purposes at the time the application for coverage of the grandchild
15 is made.

16 (b) Coverage for a grandchild of the insured under this
17 section may not be terminated solely because the covered grandchild
18 is no longer a dependent of the insured for federal income tax
19 purposes. (V.T.I.C. Art. 3.51-6, Sec. 3E, as amended Acts 77th
20 Leg., R.S., Chs. 396 and 1027.)

21 Source Law

22 Sec. 3E. (a) In this section, "health insurance
23 policy" means a group policy or contract, including a
24 group contract issued by a company subject to Chapter
25 20 of this code that provides coverage for hospital,
26 surgical, or medical expenses incurred as a result of
27 accident or sickness.

28 (b) [as amended Acts 77th Leg., R.S., Ch. 396] A
29 health insurance policy that provides coverage for a
30 child of the policyholder must upon payment of a
31 premium provide coverage for any children of the
32 policyholder's child if those children are dependents
33 of the policyholder. For purposes of this subsection,
34 a child of the policyholder's child is a dependent of
35 the policyholder regardless of whether the
36 policyholder treats the child as a dependent for
37 federal income tax purposes.

38 (b) [as amended Acts 77th Leg., R.S., Ch. 1027]
39 A health insurance policy that provides coverage for a
40 child of the policyholder must upon payment of a
41 premium provide coverage for any unmarried child of
42 the policyholder's child if the child is younger than
43 25 years of age and is a dependent of the policyholder
44 for federal income tax purposes at the time

1 application for coverage of the child is made.
2 Coverage for a child of the policyholder's child under
3 this subsection may not be terminated solely because
4 the covered child is no longer a dependent of the
5 policyholder for federal income tax purposes.

6 Revisor's Note

7 (1) Section 3E(b), V.T.I.C. Article 3.51-6,
8 refers to a "child of the policyholder." The revised
9 law substitutes "child of an insured" for "child of the
10 policyholder" because under a group policy of accident
11 and health insurance, the employer, association, or
12 trustees of a fund that obtains the policy is
13 considered to be the policyholder. See Sections
14 1(a)(1), (3), and (5), Article 3.51-6 (revised as
15 Sections 1251.051, 1251.053, and 1251.055,
16 respectively).

17 (2) Before September 1, 2001, Section 3E(b),
18 V.T.I.C. Article 3.51-6, provided that a health
19 insurance policy that provides coverage for a
20 policyholder's child must provide coverage for any
21 grandchild of the policyholder if the grandchild is a
22 dependent of the policyholder for federal income tax
23 purposes. Section 3E(b) was amended twice during the
24 77th Legislative Session. Chapter 1027, Acts of the
25 77th Legislature, Regular Session, 2001, amended
26 Section 3E(b) by limiting the required coverage for
27 grandchildren to any unmarried grandchild younger than
28 25 years of age who is a dependent of the policyholder
29 for federal income tax purposes at the time
30 application for coverage is made and by prohibiting
31 the termination of the required coverage solely
32 because the covered grandchild ceases to be a
33 dependent of the policyholder for federal income tax
34 purposes. Chapter 396, Acts of the 77th Legislature,
35 Regular Session, 2001, amended Section 3E(b) by
36 requiring coverage of a dependent grandchild

1 regardless of whether the grandchild is a dependent of
2 the policyholder for federal income tax purposes.
3 Under basic rules of statutory construction, codified
4 in Sections 311.025 and 312.014, Government Code, if
5 it is impossible to read two acts of the same
6 legislative session together so that effect may be
7 given to both, the latest enactment is read as an
8 implied repeal of the earlier act to the extent of the
9 conflict. The last legislative action on Chapter 396
10 occurred on May 15, 2001. The last legislative action
11 on Chapter 1027 occurred on May 22, 2001. Under
12 Sections 311.025 and 312.014, Government Code, the
13 amendment to Section 3E(b), Article 3.51-6, made by
14 Chapter 1027 that requires a grandchild to be a
15 dependent of the policyholder for federal income tax
16 purposes impliedly repealed the amendment adopted
17 under Chapter 396 that requires coverage of a
18 dependent grandchild regardless of whether the
19 grandchild is a dependent of the policyholder for
20 federal income tax purposes. The revised law
21 accordingly is drafted to reflect the amendment to
22 Section 3E(b) made by Chapter 1027.

23 Revised Law

24 Sec. 1251.152. OPTIONAL COVERAGE FOR SPOUSES AND
25 DEPENDENTS. (a) For purposes of this section, "dependent"
26 includes:

- 27 (1) a child of an employee or member who is:
28 (A) unmarried; and
29 (B) younger than 25 years of age; and
30 (2) a grandchild of an employee or member who is:
31 (A) unmarried;
32 (B) younger than 25 years of age; and
33 (C) a dependent of the insured for federal income
34 tax purposes at the time the application for coverage of the

1 grandchild is made.

2 (b) A group accident and health insurance policy may provide
3 coverage for the spouse or a dependent of an employee or member.
4 (V.T.I.C. Art. 3.51-6, Sec. 1(b), as amended Acts 77th Leg., R.S.,
5 Chs. 396 and 1027.)

6 Source Law

7 (b) [as amended Acts 77th Leg., R.S., Ch. 396]
8 The spouse and dependents of employees or members,
9 including a dependent grandchild of an employee or
10 member who is less than 21 years old and living with
11 and in the household of the employee or member,
12 referred to in Subdivisions (a)(1) through (a)(6) of
13 this section may be included within the coverage
14 provided in a group policy. For purposes of this
15 subsection, a grandchild of an employee or member is a
16 dependent of the employee or member, regardless of
17 whether the employee or member treats the grandchild
18 as a dependent for federal income tax purposes.

19 (b) [as amended Acts 77th Leg., R.S., Ch. 1027]
20 The spouse and dependents of employees or members
21 described by Subsections (a)(1)-(6) of this section,
22 including an unmarried child less than 25 years old and
23 a grandchild described by Section 3E of this article,
24 may be included within the coverage provided in a group
25 policy.

26 Revisor's Note

27 Before September 1, 2001, Section 1(b), V.T.I.C.
28 Article 3.51-6, included a dependent grandchild as a
29 dependent of an employee or member if the grandchild is
30 younger than 21 years of age and living with and in the
31 household of the employee or member. Section 1(b) was
32 amended twice during the 77th Legislative Session.
33 Chapter 1027, Acts of the 77th Legislature, Regular
34 Session, 2001, amended Section 1(b) by including as a
35 dependent of the employee or member an unmarried child
36 who is younger than 25 years of age and an unmarried
37 grandchild described by Section 3E, V.T.I.C. Article
38 3.51-6. Section 3E describes an unmarried grandchild
39 who is younger than 25 years of age and is a dependent
40 of the insured for federal income tax purposes.
41 Chapter 396, Acts of the 77th Legislature, Regular
42 Session, 2001, amended Section 1(b) by providing that

1 a grandchild is a dependent of the employee or member,
2 regardless of whether the employee or member treats
3 the grandchild as a dependent for federal income tax
4 purposes. Under basic rules of statutory construction,
5 codified in Sections 311.025 and 312.014, Government
6 Code, if it is impossible to read two acts of the same
7 legislative session together so that effect may be
8 given to both, the latest enactment is read as an
9 implied repeal of the earlier act to the extent of the
10 conflict. The last legislative action on Chapter 396
11 occurred on May 15, 2001. The last legislative action
12 on Chapter 1027 occurred on May 22, 2001. Under
13 Sections 311.025 and 312.014, Government Code, the
14 amendment to Section 1(b) made by Chapter 1027 that
15 includes as a dependent of the employee or member a
16 grandchild who is a dependent of the employee or member
17 for federal income tax purposes impliedly repealed the
18 amendment adopted under Chapter 396 that provides that
19 a grandchild is a dependent of the employee or member
20 regardless of whether the grandchild is treated as a
21 dependent for federal income tax purposes. The
22 revised law accordingly is drafted to reflect the
23 amendment to Section 1(b) made by Chapter 1027.

24 Revised Law

25 Sec. 1251.153. OPTIONAL CONTINUATION OF DEPENDENTS'
26 BENEFITS ON DEATH OF INSURED. (a) A group accident and health
27 insurance policy that provides for the payment by the insurer of
28 benefits for members of the family or dependents of an insured may
29 provide for a continuation of all or part of those benefits after
30 the death of the insured.

31 (b) Insurance provided by benefits described by Subsection
32 (a) is not life insurance under Title 7.

33 (c) Coverage described by Subsection (a) may continue for
34 any period subject to any other policy provisions relating to the

1 termination of a dependent's coverage. (V.T.I.C. Art. 3.51-6, Sec.
2 1(f).)

3 Source Law

4 (f) Any group accident and health insurance
5 policy which contains provisions for the payment by
6 the insurer of benefits for members of the family or
7 dependents of a person in the insured group may provide
8 for a continuation of such benefits or any part thereof
9 after the death of the person in the insured group and
10 provided further that any amounts of insurance so
11 provided by such benefits shall not be construed as
12 life insurance under this chapter. Such coverage may
13 continue for any period subject to any other policy
14 provisions relating to termination of dependent's
15 coverage.

16 Revisor's Note

17 Section 1(f), V.T.I.C. Article 3.51-6, refers to
18 "life insurance under this chapter," meaning V.T.I.C.
19 Chapter 3. The provisions of Chapter 3 relating to
20 life insurance are revised as Title 7 of this code.
21 The revised law is drafted accordingly.

22 Revised Law

23 Sec. 1251.154. COVERAGE FOR ADOPTED CHILDREN. A group
24 policy or contract of insurance for hospital, surgical, or medical
25 expenses incurred as a result of accident or sickness, including a
26 group contract issued by a group hospital service corporation, that
27 provides coverage for the immediate family or a child of an insured
28 may not exclude from coverage or limit coverage of a child of the
29 insured solely because the child is adopted. A child is considered
30 to be the child of an insured if the insured is a party to a suit in
31 which the insured seeks to adopt the child. (V.T.I.C. Art. 3.51-6,
32 Sec. 3D.)

33 Source Law

34 Sec. 3D. (a) In this section, "health
35 insurance" means a group policy or contract, including
36 group contracts issued by companies subject to Chapter
37 20, Insurance Code, that provides insurance for
38 hospital, surgical, or medical expenses incurred as a
39 result of accident or sickness.

40 (b) A health insurance policy that provides
41 coverage for the immediate family or children of a
42 person insured under the policy may not exclude from
43 coverage or limit coverage to a child of the insured
44 solely because the child is adopted.

45 (c) For the purposes of this section, a child is

1 considered to be the child of an insured if the insured
2 is a party in a suit in which the adoption of the child
3 by the insured is sought.

4 [Sections 1251.155-1251.200 reserved for expansion]

5 SUBCHAPTER E. GROUP ACCIDENT AND HEALTH INSURANCE: GENERAL

6 PROVISIONS

7 Revised Law

8 Sec. 1251.201. CERTIFICATE OF INSURANCE. (a) An insurer
9 issuing a group policy under this chapter shall provide to the
10 policyholder for delivery to each employee or member of the insured
11 group a certificate of insurance that:

12 (1) summarizes the essential features of the insurance
13 coverage of the employee or member; and

14 (2) states the person to whom benefits are payable.

15 (b) If dependents are included in the coverage, an insurer
16 is not required to provide more than one certificate for each family
17 unit. (V.T.I.C. Art. 3.51-6, Sec. 1(c).)

18 Source Law

19 (c) An insurer issuing a group policy under this
20 article shall furnish to the policyholder for delivery
21 to each employee or member of the insured group a
22 certificate of insurance which shall contain a
23 statement, in summary form, of the essential features
24 of the insurance coverage of such employee or member
25 and to whom benefits are payable. If dependents are
26 included in the coverage, only one certificate need be
27 issued for each family unit.

28 [Sections 1251.202-1251.250 reserved for expansion]

29 SUBCHAPTER F. CONTINUATION OR CONVERSION PRIVILEGE ON

30 TERMINATION OF COVERAGE UNDER GROUP POLICY

31 Revised Law

32 Sec. 1251.251. CONTINUATION OF GROUP COVERAGE REQUIRED;
33 EXCEPTION. (a) An insurer or group hospital service corporation
34 that issues policies that provide hospital, surgical, or major
35 medical expense insurance coverage or any combination of those
36 coverages on an expense incurred basis shall, as required by this
37 subchapter, provide continuation of group coverage for employees or
38 members and their eligible dependents, subject to the eligibility
39 provisions prescribed by Section 1251.252.

1 (b) This subchapter does not apply to an insurance policy
2 that provides benefits only for expenses incurred because of a
3 specified disease or an accident. (V.T.I.C. Art. 3.51-6, Secs.
4 1(d)(3) (part), (3)(A)(i).)

5 Source Law

6 (3) Any insurer or group hospital service
7 corporation subject to Chapter 20, Insurance Code, who
8 issues policies which provide hospital, surgical, or
9 major medical expense insurance or any combination of
10 these coverages on an expense incurred basis, but not a
11 policy which provides benefits for specified disease
12 or for accident only, shall provide a group
13 continuation privilege as required by this
14 subsection. . . .

15 (A)(i) Policies subject to this
16 section shall provide continuation of group coverage
17 for employees or members and their eligible dependents
18 subject to the eligibility provisions.

19 Revised Law

20 Sec. 1251.252. ELIGIBILITY FOR CONTINUATION OF GROUP
21 COVERAGE. (a) An employee, member, or dependent is entitled to
22 continuation of group coverage if:

23 (1) the individual's coverage under the group policy
24 is terminated for any reason other than involuntary termination for
25 cause, including discontinuance of the group policy in its entirety
26 or with respect to an insured class; and

27 (2) the individual has been continuously insured under
28 the group policy, or under any group policy providing similar
29 benefits that the policy replaces, for at least three consecutive
30 months immediately before termination.

31 (b) For purposes of Subsection (a), involuntary termination
32 for cause does not include termination for any health-related
33 cause. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(3) (part).)

34 Source Law

35 (3) . . . Any employee, member, or
36 dependent whose insurance under the group policy has
37 been terminated for any reason except involuntary
38 termination for cause, including discontinuance of the
39 group policy in its entirety or with respect to an
40 insured class, and who has been continuously insured
41 under the group policy and under any group policy
42 providing similar benefits which it replaces for at
43 least three consecutive months immediately prior to
44 termination shall be entitled to such privilege as
45 outlined in Paragraph (A) below. Involuntary

1 termination for cause does not include termination for
2 any health-related cause.

3 Revised Law

4 Sec. 1251.253. REQUEST FOR CONTINUATION OF GROUP
5 COVERAGE. An employee, member, or dependent must request in
6 writing the continuation of group coverage not later than the 31st
7 day after the later of:

8 (1) the date the group coverage would otherwise
9 terminate; or

10 (2) the date the individual is given, in a format
11 prescribed by the commissioner, notice by either the employer or
12 the group policyholder of the right to continuation of group
13 coverage. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(3)(A)(ii).)

14 Source Law

15 (ii) Continuation of group
16 coverage must be requested in writing within 31 days
17 following the later of: (aa) the date the group
18 coverage would otherwise terminate; or (bb) the date
19 the employee, member, or dependent is given notice in a
20 format prescribed by the commissioner of the right of
21 continuation by either the employer or the group
22 policyholder.

23 Revised Law

24 Sec. 1251.254. PAYMENT OF CONTRIBUTIONS. (a) An employee,
25 member, or dependent who elects to continue group coverage under
26 this subchapter must pay to the employer or group policyholder,
27 each month in advance, the amount of contribution required by the
28 employer or policyholder, plus two percent of the group rate for the
29 coverage being continued under the group policy on the due date of
30 each payment.

31 (b) The employee's, member's, or dependent's written
32 election for continuation of group coverage, together with the
33 first contribution required to establish advance monthly
34 contributions, must be given to the employer or policyholder not
35 later than the later of:

36 (1) the 31st day after the date coverage would
37 otherwise terminate; or

38 (2) the date the individual is given notice by either

1 the employer or the group policyholder of the right to continuation
2 of group coverage. (V.T.I.C. Art. 3.51-6, Secs. 1(d)(3)(A)(iii),
3 (iv).)

4 Source Law

5 (iii) An employee, member, or
6 dependent electing continuation must pay to the group
7 policyholder or employer, on a monthly basis in
8 advance, the amount of contribution required by the
9 policyholder or employer, plus two percent of the
10 group rate for the insurance being continued under the
11 group policy on the due date of each payment.

12 (iv) The employee's, member's,
13 or dependent's written election of continuation,
14 together with the first contribution required to
15 establish contributions on a monthly basis in advance,
16 must be given to the policyholder or employer within
17 the later of: (aa) 31 days of the date coverage would
18 otherwise terminate, or (bb) the date the employee is
19 given notice of the right of continuation by either the
20 employer or the group policyholder.

21 Revised Law

22 Sec. 1251.255. TERMINATION OF CONTINUED COVERAGE. (a)

23 Group coverage continued under this subchapter may not terminate
24 until the earliest of:

25 (1) six months after the date the employee, member, or
26 dependent elects to continue the group coverage;

27 (2) the date failure to make timely payments would
28 terminate the group coverage;

29 (3) the date the group coverage terminates in its
30 entirety;

31 (4) the date the insured is or could be covered under
32 Medicare;

33 (5) the date the insured is covered for similar
34 benefits by another plan or program, including:

35 (A) a hospital, surgical, medical, or major
36 medical expense insurance policy;

37 (B) a hospital or medical service subscriber
38 contract; or

39 (C) a medical practice or other prepayment plan;

40 (6) the date the insured is eligible for similar
41 benefits, whether or not covered for those benefits, under any

1 arrangement of coverage for individuals in a group, whether on an
2 insured or uninsured basis; or

3 (7) the date similar benefits are provided or
4 available to the insured under any state or federal law.

5 (b) Not later than the 30th day before the end of the six
6 months after the date the employee, member, or dependent elects to
7 continue group coverage under the policy, the insurer shall:

8 (1) notify the individual that the individual may be
9 eligible for coverage under the Texas Health Insurance Risk Pool as
10 provided by Chapter 1506; and

11 (2) provide to the individual the address for applying
12 to that pool. (V.T.I.C. Art. 3.51-6, Secs. 1(d)(3)(A)(v), (vi).)

13 Source Law

14 (v) Continuation may not
15 terminate until the earliest of: (aa) six months after
16 the date the election is made; (bb) the date on which
17 failure to make timely payments would terminate
18 coverage; (cc) the date on which the group coverage
19 terminates in its entirety; (dd) the date on which the
20 covered person is or could be covered under Medicare;
21 (ee) the date on which the covered person is covered
22 for similar benefits by another hospital, surgical,
23 medical, or major medical expense insurance policy or
24 hospital or medical service subscriber contract or
25 medical practice or other prepayment plan or any other
26 plan or program; (ff) the date the covered person is
27 eligible for similar benefits whether or not covered
28 therefor under any arrangement of coverage for
29 individuals in a group, whether on an insured or
30 uninsured basis; or (gg) similar benefits are provided
31 or available to such person, pursuant to or in
32 accordance with the requirements of any state or
33 federal law.

34 (vi) Not less than 30 days
35 before the end of the six months after the date the
36 employee, member, or dependent elects continuation of
37 the policy, the insurer shall notify the employee,
38 member, or dependent that he/she may be eligible for
39 coverage under the Texas Health Insurance Risk Pool,
40 as provided under Article 3.77 of this code, and the
41 insurer shall provide the address for applying to such
42 pool to the employee, member, or dependent.

43 Revised Law

44 Sec. 1251.256. CONVERSION OF GROUP POLICY. (a) An
45 insurer may offer a conversion policy to each employee, member, or
46 dependent who is covered under a group accident and health
47 insurance policy that is terminating.

48 (b) If offered, an issuer shall issue a conversion policy

1 without evidence of insurability if a written application for the
2 policy and payment of the first premium are made not later than the
3 31st day after the date of termination.

4 (c) Any conversion policy must meet the minimum standards
5 for benefits for conversion policies.

6 (d) The insurer may provide the conversion coverage on an
7 individual or group basis. (V.T.I.C. Art. 3.51-6, Secs.
8 1(d)(3)(B)(i), (iii).)

9 Source Law

10 (B)(i) An insurer may offer to each
11 employee, member, or dependent a conversion policy.
12 Such a conversion policy shall be issued without
13 evidence of insurability if a written application for
14 the policy and payment of the first premium are made
15 not later than the 31st day after the date of
16 termination. The conversion policy shall meet the
17 minimum standards for benefits for conversion
18 policies.

19 (iii) The insurer may elect to
20 provide the conversion coverage on an individual or
21 group basis.

22 Revised Law

23 Sec. 1251.257. PREMIUM FOR CONVERTED POLICY. (a) An
24 insurer shall determine the premium for a converted policy issued
25 under this subchapter in accordance with the insurer's table of
26 premium rates for coverage that was provided under the group
27 policy. The premium:

28 (1) must be based on the type of converted policy and
29 the coverage provided by the policy; and

30 (2) may be based on the age and geographic location of
31 each individual to be covered.

32 (b) The premium for the same coverage and benefits under a
33 converted policy may not exceed 200 percent of the premium
34 determined for the group policy in accordance with Subsection (a).
35 (V.T.I.C. Art. 3.51-6, Sec. 1(d)(3) (part).)

36 Source Law

37 (3) . . .
38 The premium for the converted policy issued
39 under Paragraph (B) of this subdivision shall be
40 determined in accordance with the insurer's table of
41 premium rates for coverage that was provided under the

1 group policy or plan. The premium may be based on the
2 age and geographic location of each person to be
3 covered and the type of converted policy. The premium
4 for the same coverage and benefits under a converted
5 policy may not exceed 200 percent of the premium
6 determined in accordance with this paragraph. The
7 premium must be based on the type of converted policy
8 and the coverage provided by the policy.

9 Revised Law

10 Sec. 1251.258. BENEFITS UNDER CONVERTED POLICY. The
11 commissioner by rule shall establish minimum standards for benefits
12 under converted policies issued under this subchapter. (V.T.I.C.
13 Art. 3.51-6, Sec. 1(d)(3)(B)(ii) (part).)

14 Source Law

15 (ii) . . . The commissioner
16 shall issue rules and regulations to establish minimum
17 standards for benefits under policies issued pursuant
18 to this paragraph.

19 Revisor's Note

20 Section 1(d)(3)(B)(ii), V.T.I.C. Article 3.51-6,
21 refers to "rules and regulations." The revised law
22 omits the reference to "regulations" for the reason
23 stated in the revisor's note to Section 1251.008.

24 Revised Law

25 Sec. 1251.259. TERMINATION OF CONVERTED POLICY. Conversion
26 coverage under this subchapter for an insured may not terminate
27 until the earlier of:

28 (1) the date failure to make timely payments would
29 terminate coverage; or

30 (2) the date of an event specified by Section
31 1251.255(a)(4), (5), (6), or (7) for termination of continued group
32 coverage. (V.T.I.C. Art. 3.51-6, Sec. 1(d)(3)(B)(ii) (part).)

33 Source Law

34 (ii) Conversion coverage for
35 any insured person may not terminate until the
36 earliest of: (aa) the date on which failure to make
37 timely payments would terminate coverage; or (bb) one
38 of the conditions specified in items (dd) through (gg)
39 of Subparagraph (v), Paragraph (A), of this
40 subdivision. . . .

41 Revised Law

42 Sec. 1251.260. NOTICE OF CONTINUATION AND CONVERSION

1 PRIVILEGES. (a) An employer that provides to its employees group
2 accident and health insurance coverage that includes a group
3 continuation or conversion privilege on termination of coverage
4 shall give written notice of the continuation or conversion
5 privileges under the policy to each employee or dependent insured
6 under the group and affected by the termination.

7 (b) The commissioner by rule shall establish minimum
8 standards for the notice required by this section. (V.T.I.C. Art.
9 3.51-6, Sec. 3C, as added Acts 71st Leg., R.S., Ch. 1041, Sec. 10.)

10 Source Law

11 Sec. 3C. (a) An employer that provides to its
12 employees group accident and health insurance coverage
13 that includes a conversion or group continuation
14 privilege on termination of coverage shall give
15 written notice to each employee, member, or dependent
16 insured under the group and affected by the
17 termination of this conversion or group continuation
18 privileges under the policy.

19 (b) The State Board of Insurance by rule shall
20 establish minimum standards for the notice required by
21 this section.

22 Revisor's Note

23 Section 3C, V.T.I.C. Article 3.51-6, as added by
24 Chapter 1041, Acts of the 71st Legislature, Regular
25 Session, 1989, requires an employer that provides
26 group accident and health insurance to its employees
27 to give written notice of any continuation or
28 conversion privileges under the policy to "each
29 employee, member, or dependent." The revised law
30 omits as unnecessary the reference to each "member"
31 because under a policy issued to an employer, the only
32 individuals covered are employees and their
33 dependents.

34 [Sections 1251.261-1251.300 reserved for expansion]

35 SUBCHAPTER G. CONTINUATION OF GROUP COVERAGE FOR CERTAIN
36 FAMILY MEMBERS AND DEPENDENTS

37 Revised Law

38 Sec. 1251.301. CONTINUATION OF GROUP COVERAGE. A group
39 policy or contract delivered, issued for delivery, renewed,

1 amended, or extended in this state, including a group contract
2 issued by a group hospital service corporation, that provides
3 insurance for hospital, surgical, or medical expenses incurred as a
4 result of accident or sickness must include an option for each
5 individual covered by the policy or contract because of a family or
6 dependent relationship to an individual who is a member of the group
7 for which the policy or contract is provided to continue coverage
8 with the group if the individual's eligibility for coverage under
9 the policy or contract ends because of:

10 (1) the severance of the family relationship; or

11 (2) the retirement or death of the group member.

12 (V.T.I.C. Art. 3.51-6, Secs. 3B(a), (b) (part).)

13 Source Law

14 Sec. 3B. (a) In this section, "health
15 insurance policy" means a group policy or contract,
16 including group contracts issued by companies subject
17 to Chapter 20 of this code and the Texas Health
18 Maintenance Organization Act (Chapter 20A, Vernon's
19 Texas Insurance Code), providing insurance for
20 hospital, surgical, or medical expenses incurred as a
21 result of an accident or sickness.

22 (b) Each health insurance policy delivered,
23 issued for delivery, renewed, amended, or extended in
24 this state shall include an option for each person
25 covered by the policy by virtue of family or dependent
26 relationship to a person who is a member of the group
27 for which the health insurance policy is provided to
28 continue coverage with the group if:

29 (1) previous eligibility for coverage
30 under the health insurance policy ceases because of
31 the severance of the family relationship or the
32 retirement or death of the member of the group; and
33 . . .

34 Revisor's Note

35 (1) Section 3B(a), V.T.I.C. Article 3.51-6,
36 refers to "companies subject to . . . the Texas Health
37 Maintenance Organization Act (Chapter 20A, Vernon's
38 Texas Insurance Code)." The revised law omits the
39 reference as unnecessary because it duplicates the
40 substance of Section 843.051(b)(1) of this code.

41 (2) Section 3B(b), V.T.I.C. Article 3.51-6,
42 refers to a "health insurance policy." Throughout
43 this subchapter, the revised law substitutes "health

1 insurance policy or contract" because Section 3B
2 applies to contracts for nonprofit hospital service
3 plans. See Section 3B(a) (revised as this section).

4 Revised Law

5 Sec. 1251.302. ELIGIBILITY FOR CONTINUED COVERAGE. A
6 family member or dependent of an insured is eligible for continued
7 coverage under this subchapter if the family member or dependent:

8 (1) has been a member of the group for a period of at
9 least one year; or

10 (2) is an infant under one year of age. (V.T.I.C. Art.
11 3.51-6, Sec. 3B(b) (part).)

12 Source Law

13 [(b) Each health insurance policy delivered,
14 issued for delivery, renewed, amended, or extended in
15 this state shall include an option for each person
16 covered by the policy by virtue of family or dependent
17 relationship to a person who is a member of the group
18 for which the health insurance policy is provided to
19 continue coverage with the group if:]

20
21 (2) the family member or dependent has
22 been a member of the group for a period of at least one
23 year or is an infant under one year of age.

24 Revised Law

25 Sec. 1251.303. PHYSICAL EXAMINATION NOT REQUIRED. An
26 individual who exercises the option to continue group coverage
27 under this subchapter may not be required to take and pass a
28 physical examination as a condition to continuing coverage.
29 (V.T.I.C. Art. 3.51-6, Sec. 3B(c).)

30 Source Law

31 (c) A person who exercises the option provided
32 by Subsection (b) of this section may not be required
33 to take and pass a physical examination as a condition
34 for continuing coverage.

35 Revised Law

36 Sec. 1251.304. SCOPE OF COVERAGE. (a) An individual
37 covered under group continuation coverage under this subchapter is
38 entitled to coverage that is identical in scope to the coverage
39 provided under the group health insurance policy or contract. An
40 exclusion that was not included in the health insurance policy or

1 contract may not be included in the group continuation coverage.

2 (b) If the group policyholder or contract holder replaces
3 the health insurance policy or contract within the period
4 prescribed by Section 1251.310(3), an individual covered under
5 group continuation coverage may obtain coverage identical in scope
6 to the coverage under the replacement group policy as provided by
7 this subchapter. (V.T.I.C. Art. 3.51-6, Sec. 3B(d).)

8 Source Law

9 (d) If a person exercises the option provided by
10 Subsection (b) of this section, that person is
11 entitled to coverage that is identical in scope to the
12 coverage provided under the health insurance policy,
13 and exclusions that were not included in the health
14 insurance policy may not be included in the group
15 continuation coverage. However, if the group
16 policyholder replaces the health insurance policy
17 within the one-year period provided by Subdivision (4)
18 of Subsection (1) of this section, the person may
19 obtain coverage identical in scope to the coverage
20 under the replacement group policy as provided by this
21 article.

22 Revisor's Note

23 Section 3B(d), V.T.I.C. Article 3.51-6, refers to
24 "the one-year period provided by Subdivision (4) of
25 Subsection (1) of this section." As originally
26 enacted by Chapter 673, Acts of the 69th Legislature,
27 Regular Session, 1985, Section 3B(1)(4) provided that
28 continued coverage could not terminate until "a period
29 of one year has elapsed since the severance of the
30 family relationship or the retirement or death of the
31 member of the group." Chapter 377, Acts of the 71st
32 Legislature, Regular Session, 1989, amended Section
33 3B(1) by deleting the existing Subdivision (2),
34 renumbering existing Subdivisions (3) and (4) as (2)
35 and (3), respectively, and changing "one year" in
36 existing Subdivision (4) to "three years." Section
37 3B(1)(3) is revised as Section 1251.310(3), and the
38 revised law is drafted accordingly.

39 Revised Law

40 Sec. 1251.305. AMOUNT OF PREMIUM. Except as provided by

1 Section 1551.064, the premium for continuation of a spouse or
2 dependent on the group health insurance policy or contract may not
3 be more than the premium charged under the group policy or contract
4 for the individual had the family relationship not been severed.
5 (V.T.I.C. Art. 3.51-6, Sec. 3B(f).)

6 Source Law

7 (f) Except as provided in Subsection (m) of this
8 section, a premium for continuation of the spouse or
9 dependent on the group policy shall be no more than the
10 premium charged under the group contract for the
11 spouse or dependent had the family relationship not
12 been severed.

13 Revised Law

14 Sec. 1251.306. PAYMENT OF PREMIUMS. (a) An individual
15 covered under group continuation coverage under this subchapter
16 shall pay premiums for the coverage directly to the group
17 policyholder or contract holder.

18 (b) The coverage must provide the individual with the option
19 of paying the premiums in monthly installments.

20 (c) The group policyholder or contract holder may require
21 the individual to pay a monthly fee of not more than \$5 for
22 administrative costs. (V.T.I.C. Art. 3.51-6, Sec. 3B(e).)

23 Source Law

24 (e) A person covered under group continuation
25 coverage shall pay premiums for the coverage directly
26 to the group policyholder, and the coverage shall
27 provide the person with the option of paying the
28 premiums in monthly installments. The group
29 policyholder may require the person to pay a fee of not
30 more than \$5 a month for administrative costs.

31 Revised Law

32 Sec. 1251.307. NOTICE OF CONTINUATION OPTION. Except as
33 provided by Section 1551.064, at the time a health insurance policy
34 or contract is issued, the group policyholder or contract holder
35 shall give written notice to each group member and each dependent of
36 a group member covered by the policy or contract of the continuation
37 option under this subchapter. (V.T.I.C. Art. 3.51-6, Sec. 3B(g).)

38 Source Law

39 (g) Except as provided in Subsection (m) of this
40 section, at the time the health insurance policy is

1 issued, the group policyholder shall give written
2 notice to each member of the group and each dependent
3 of a member of the group covered by a health insurance
4 policy of the continuation option.

5 Revised Law

6 Sec. 1251.308. NOTICE OF SEVERANCE OF FAMILY RELATIONSHIP;
7 NOTICE OF DESIRE TO EXERCISE OPTION. (a) Except as provided by
8 Section 1551.064, each group health insurance policy or contract
9 must require a group member to give written notice to the group
10 policyholder or contract holder not later than the 15th day after
11 the date of any severance of the family relationship that might
12 activate the continuation option under this subchapter. Written
13 notice under this subsection may be given by the group member's
14 dependent.

15 (b) On receipt of notice under Subsection (a), the group
16 policyholder or contract holder shall immediately give written
17 notice of the continuation option under this subchapter to each
18 affected dependent of the group member.

19 (c) On receipt of notice of the death or retirement of a
20 group member, the group policyholder or contract holder shall
21 immediately give written notice of the continuation option under
22 this subchapter to each dependent of the group member. The notice
23 must state the amount of the premium to be charged and must be
24 accompanied by any necessary enrollment forms.

25 (d) Not later than the 60th day after the date of the
26 severance of the family relationship or the retirement or death of
27 the group member, a dependent must give written notice to the group
28 policyholder or contract holder of the individual's desire to
29 exercise the continuation option under this subchapter. Coverage
30 under the health insurance policy or contract remains in effect
31 during the period prescribed by this subsection if the policy or
32 contract premiums are paid.

33 (e) If a dependent does not give written notice of the
34 individual's desire to exercise the continuation option under this
35 subchapter within the time prescribed by Subsection (d), the option
36 expires. (V.T.I.C. Art. 3.51-6, Secs. 3B(h), (i).)

1 Source Law

2 (h) Except as provided in Subsection (m) of this
3 section, each health insurance policy shall require a
4 member of the group to give written notice to the group
5 policyholder within 15 days of any severance of the
6 family relationship that might activate the
7 continuation option under Subsection (b) of this
8 section, and the group policyholder on receiving this
9 notice shall immediately give written notice to each
10 affected dependent of the continuation option;
11 however, such written notice may be given by the group
12 member's dependent. On receipt of notice of the death
13 or retirement of a group member, the group
14 policyholder shall immediately give written notice to
15 the group member's dependents of the continuation
16 option under Subsection (b) of this section. Such
17 notice shall include a statement of the amount of the
18 premium to be charged and shall be accompanied by any
19 necessary enrollment forms.

20 (i) Within 60 days from the severance of the
21 family relationship or the retirement or death of the
22 member of the group, the dependent must give written
23 notice to the group policyholder of the desire to
24 exercise the option under Subsection (b) of this
25 section or the option expires. Coverage under the
26 health insurance policy remains in effect during this
27 60-day period provided the policy premiums are paid.

28 Revised Law

29 Sec. 1251.309. CONTINUATION OF CERTAIN COVERAGES. (a) Any
30 period of previous coverage under the health insurance policy or
31 contract, including a policy or contract executed under Chapter
32 1551, must be used in full or partial satisfaction of any required
33 probationary or waiting periods provided in the contract for
34 dependent coverage.

35 (b) If a health insurance policy or contract provides to a
36 group member continuation rights to cover the period between the
37 time the member retires and the time the member is eligible for
38 coverage by Medicare, those same continuation rights must be made
39 available to the group member's dependents. (V.T.I.C. Art. 3.51-6,
40 Secs. 3B(j), (k).)

41 Source Law

42 (j) Any period of previous coverage under the
43 health insurance policy is to be used in full or
44 partial satisfaction of any required probationary or
45 waiting periods provided in the contract for dependent
46 coverage.

47 (k) If a health insurance policy provides to a
48 group member continuation rights to cover the period
49 between the time that the member retires and the time
50 of eligibility for coverage by Medicare, those same
51 continuation rights shall be made available to the

1 group member's dependents.

2 Revisor's Note

3 The revised law adds "including a policy or
4 contract executed under Chapter 1551" to Section
5 1251.309(a) for the convenience of the reader and to
6 maintain the textual linkage between this provision
7 and Chapter 1551 of this code. Section 3B(m), V.T.I.C.
8 Article 3.51-6, revised as Section 1551.064 of this
9 code, contained an explicit reference to the Texas
10 Employees Group Benefits Act (V.T.I.C. Article
11 3.50-2), revised as Chapter 1551 of this code. The
12 addition of the referenced language to Section
13 1251.309(a) maintains that explicit reference in the
14 context in which it appeared.

15 Revised Law

16 Sec. 1251.310. TERMINATION OF CONTINUED COVERAGE. The
17 coverage of an individual who exercises the continuation option
18 under this subchapter continues without interruption and may not be
19 canceled or otherwise terminated until:

20 (1) the insured fails to make a premium payment within
21 the time required to make the payment;

22 (2) the insured becomes eligible for substantially
23 similar coverage under another plan or program, including a group
24 health insurance policy or contract, hospital or medical service
25 subscriber contract, or medical practice or other prepayment plan;
26 or

27 (3) the third anniversary of:

28 (A) the severance of the family relationship; or

29 (B) the retirement or death of the group member.

30 (V.T.I.C. Art. 3.51-6, Sec. 3B(1).)

31 Source Law

32 (1) If a person exercises the continuation
33 option under Subsection (b) of this section, coverage
34 of that person continues without interruption and may
35 not be cancelled or otherwise terminated until:

36 (1) the insured fails to make a premium
37 payment in the time required to make that payment;

1 (2) the insured becomes eligible for
2 substantially similar coverage under another health
3 insurance policy, hospital or medical service
4 subscriber contract, medical practice or other
5 prepayment plan, or by any other plan or program; or

6 (3) a period of three years has elapsed
7 since the severance of the family relationship or the
8 retirement or death of the member of the group.

9 [Sections 1251.311-1251.350 reserved for expansion]

10 SUBCHAPTER H. BLANKET ACCIDENT AND HEALTH INSURANCE:

11 ELIGIBLE POLICYHOLDERS

12 Revised Law

13 Sec. 1251.351. COMMON CARRIER OR MOTOR VEHICLE RENTAL OR
14 LEASING COMPANY. (a) A blanket accident and health insurance
15 policy may be issued to:

16 (1) a common carrier or the operator, owner, or lessor
17 of a means of transportation to cover a group of individuals who may
18 become passengers defined by reference to their travel status on
19 the common carrier or means of transportation; or

20 (2) an automobile or truck rental or leasing company
21 to cover a group of individuals who may become renters, lessees, or
22 passengers defined by their travel status on the rented or leased
23 vehicles.

24 (b) The common carrier, the operator, owner, or lessor of a
25 means of transportation, or the automobile or truck rental or
26 leasing company is the policyholder under a policy to which this
27 section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

28 Source Law

29 [(a) Blanket accident and health insurance is
30 hereby defined to be that form of accident, health, or
31 accident and health insurance covering groups of
32 persons as provided in (1) through (9) below:]

33 (1) under a policy issued to any common
34 carrier or to any operator, owner, or lessor of a means
35 of transportation, who or which shall be deemed the
36 policyholder, covering a group of persons who may
37 become passengers defined by reference to their travel
38 status on such common carrier or such means of
39 transportation; or, under a policy issued to any
40 automobile and/or truck leasing company, which shall
41 be deemed the policyholder, covering a group of
42 persons who may become either renters, lessees, or
43 passengers defined by their travel status on such
44 rented or leased vehicles;

45 . . .

1 Revisor's Note

2 Section 2(a)(1), V.T.I.C. Article 3.51-6,
3 provides that a blanket accident and health insurance
4 policy may be issued to an "automobile and/or truck
5 leasing company" to cover "renters, lessees, or
6 passengers." The revised law substitutes "automobile
7 or truck rental or leasing company" for "automobile
8 and/or truck leasing company" because it is clear from
9 the reference to "renters" that a company that rents
10 automobiles or trucks may obtain a blanket accident
11 and health insurance policy.

12 Revised Law

13 Sec. 1251.352. EMPLOYERS. (a) A blanket accident and
14 health insurance policy may be issued to an employer to cover any
15 group of employees, dependents, or guests defined by reference to
16 specified hazards incident to an activity or operation of the
17 employer.

18 (b) The employer is the policyholder under a policy to which
19 this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

20 Source Law

21 [(a) Blanket accident and health insurance is
22 hereby defined to be that form of accident, health, or
23 accident and health insurance covering groups of
24 persons as provided in (1) through (9) below:]

25 . . .
26 (2) under a policy issued to an employer,
27 who shall be deemed the policyholder, covering any
28 group of employees, dependents, or guests, defined by
29 reference to specified hazards incident to an activity
30 or activities or operations of the policyholder;
31 . . .

32 Revised Law

33 Sec. 1251.353. EDUCATIONAL INSTITUTIONS. (a) A blanket
34 accident and health insurance policy may be issued to a college,
35 school, or other institution of learning, to a school district or
36 school jurisdictional unit, or to the head, principal, or governing
37 board of such an educational unit to cover students, teachers, or
38 employees.

39 (b) The institution, head, principal, or governing board is

1 the policyholder under a policy to which this section applies.
2 (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

3 Source Law

4 [(a) Blanket accident and health insurance is
5 hereby defined to be that form of accident, health, or
6 accident and health insurance covering groups of
7 persons as provided in (1) through (9) below:]

8 . . .
9 (3) under a policy issued to a college,
10 school, or other institution of learning, a school
11 district or districts, or school jurisdictional unit,
12 or to the head, principal, or governing board of any
13 such education unit, who or which shall be deemed the
14 policyholder, covering students, teachers, or
15 employees;
16 . . .

17 Revised Law

18 Sec. 1251.354. RELIGIOUS, CHARITABLE, RECREATIONAL,
19 EDUCATIONAL, OR CIVIC ORGANIZATION. (a) A blanket accident and
20 health insurance policy may be issued to a religious, charitable,
21 recreational, educational, or civic organization, or a branch of
22 the organization, to cover any group of members or participants
23 defined by reference to specified hazards incident to an activity
24 or operation sponsored or supervised by the organization or branch.

25 (b) The organization or branch is the policyholder under a
26 policy to which this section applies. (V.T.I.C. Art. 3.51-6, Sec.
27 2(a) (part).)

28 Source Law

29 [(a) Blanket accident and health insurance is
30 hereby defined to be that form of accident, health, or
31 accident and health insurance covering groups of
32 persons as provided in (1) through (9) below:]

33 . . .
34 (4) under a policy issued to any
35 religious, charitable, recreational, educational, or
36 civic organization, or branch thereof, which shall be
37 deemed the policyholder, covering any group of members
38 or participants defined by reference to specified
39 hazards incident to any activity or activities or
40 operations sponsored or supervised by such
41 policyholder;
42 . . .

43 Revised Law

44 Sec. 1251.355. SPORTS TEAM OR CAMP. (a) A blanket
45 accident and health insurance policy may be issued to a sports team
46 or camp or the sponsor of a sports team or camp to cover members,

1 campers, employees, officials, or supervisors.

2 (b) The sports team, camp, or sponsor is the policyholder
3 under a policy to which this section applies. (V.T.I.C. Art.
4 3.51-6, Sec. 2(a) (part).)

5 Source Law

6 [(a) Blanket accident and health insurance is
7 hereby defined to be that form of accident, health, or
8 accident and health insurance covering groups of
9 persons as provided in (1) through (9) below:]

10 . . .
11 (5) under a policy issued to a sports team,
12 camp, or sponsor thereof, which shall be deemed the
13 policyholder, covering members, campers, employees,
14 officials, or supervisors;

15 . . .

16 Revised Law

17 Sec. 1251.356. GOVERNMENTAL OR VOLUNTEER EMERGENCY
18 SERVICES ORGANIZATION. (a) A blanket accident and health
19 insurance policy may be issued to a governmental or volunteer fire
20 department or fire company, first aid or civil defense
21 organization, or similar governmental or volunteer organization to
22 cover a group of members or participants defined by reference to
23 specified hazards incident to an activity or operation sponsored or
24 supervised by the organization.

25 (b) The governmental or volunteer organization is the
26 policyholder under a policy to which this section applies.
27 (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

28 Source Law

29 [(a) Blanket accident and health insurance is
30 hereby defined to be that form of accident, health, or
31 accident and health insurance covering groups of
32 persons as provided in (1) through (9) below:]

33 . . .
34 (6) under a policy issued to any
35 governmental or volunteer fire department or fire
36 company, first aid, civil defense, or other such
37 governmental or volunteer organization, which shall be
38 deemed the policyholder, covering any group of members
39 or participants defined by reference to specified
40 hazards incident to an activity or activities or
41 operations sponsored or supervised by such
42 policyholder;

43 . . .

44 Revised Law

45 Sec. 1251.357. NEWSPAPER OR OTHER PUBLISHER. (a) A

1 blanket accident and health insurance policy may be issued to a
2 newspaper or other publisher to cover the publisher's carriers.

3 (b) The publisher is the policyholder under a policy to
4 which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a)
5 (part).)

6 Source Law

7 [(a) Blanket accident and health insurance is
8 hereby defined to be that form of accident, health, or
9 accident and health insurance covering groups of
10 persons as provided in (1) through (9) below:]

11 . . .
12 (7) under a policy issued to a newspaper or
13 other publisher, which shall be deemed the
14 policyholder, covering its carriers;

15 . . .

16 Revised Law

17 Sec. 1251.358. ASSOCIATION. (a) A blanket accident and
18 health insurance policy may be issued to an association, including
19 a labor union, to cover any group of members or participants defined
20 by reference to specified hazards incident to an activity or
21 operation sponsored or supervised by the association.

22 (b) To be eligible to obtain a blanket accident and health
23 insurance policy, an association must:

24 (1) have a constitution and bylaws; and

25 (2) have been organized and be maintained in good
26 faith for purposes other than that of obtaining insurance.

27 (c) The association is the policyholder under a policy to
28 which this section applies. (V.T.I.C. Art. 3.51-6, Sec. 2(a)
29 (part).)

30 Source Law

31 [(a) Blanket accident and health insurance is
32 hereby defined to be that form of accident, health, or
33 accident and health insurance covering groups of
34 persons as provided in (1) through (9) below:]

35 . . .
36 (8) under a policy issued to an
37 association, including a labor union, which shall have
38 a constitution and bylaws and which has been organized
39 and is maintained in good faith for purposes other than
40 that of obtaining insurance, which shall be deemed the
41 policyholder, covering any group of members or
42 participants defined by reference to specified hazards
43 incident to an activity or activities or operations
44 sponsored or supervised by such policyholder;

45 . . .

1 Revised Law

2 Sec. 1251.359. COVERAGE FOR OTHER RISKS. (a) A blanket
3 accident and health insurance policy may be issued to cover any risk
4 or class of risks other than a risk described by this subchapter
5 that, as determined by the commissioner, is eligible for blanket
6 accident and health insurance.

7 (b) The commissioner may make a determination under
8 Subsection (a) based on an individual risk, a class of risks, or
9 both. (V.T.I.C. Art. 3.51-6, Sec. 2(a) (part).)

10 Source Law

11 [(a) Blanket accident and health insurance is
12 hereby defined to be that form of accident, health, or
13 accident and health insurance covering groups of
14 persons as provided in (1) through (9) below:]

15 . . .
16 (9) under a policy issued to cover any
17 other risk or class of risks which, in the discretion
18 of the commissioner of insurance, may be properly
19 eligible for blanket accident and sickness insurance.
20 The discretion of the commissioner of insurance may be
21 exercised on an individual risk basis or class of
22 risks, or both.

23 [Sections 1251.360-1251.400 reserved for expansion]

24 SUBCHAPTER I. BLANKET ACCIDENT AND HEALTH INSURANCE:

25 GENERAL PROVISIONS

26 Revised Law

27 Sec. 1251.401. INDIVIDUAL APPLICATION AND CERTIFICATE NOT
28 REQUIRED. (a) An individual application from an insured under a
29 blanket accident and health insurance policy is not required.

30 (b) An insurer is not required to provide a certificate to
31 each insured under a blanket accident and health insurance policy.
32 (V.T.I.C. Art. 3.51-6, Sec. 2(b).)

33 Source Law

34 (b) An individual application need not be
35 required from a person covered under a blanket
36 accident and sickness policy or contract, nor shall it
37 be necessary for the insurer to furnish each person a
38 certificate.

39 Revisor's Note

40 Section 2(b), V.T.I.C. Article 3.51-6, refers to
41 a blanket accident and sickness "policy or contract."

1 The revised law omits the reference to a "contract" for
2 consistency with the remaining provisions of Section
3 2, V.T.I.C. Article 3.51-6 (revised as this
4 subchapter), which use the term "policy."

5 Revised Law

6 Sec. 1251.402. LIABILITY OF POLICYHOLDER NOT AFFECTED.
7 Subchapter H and this subchapter do not affect the legal liability
8 of a policyholder for the death of or injury to a member of a group.
9 (V.T.I.C. Art. 3.51-6, Sec. 2(c).)

10 Source Law

11 (c) Nothing in this section shall be deemed to
12 affect the legal liability of any policyholder for the
13 death of or injury to any member of a group.

14 [Sections 1251.403-1251.450 reserved for expansion]

15 SUBCHAPTER J. REGULATION OF OUT-OF-STATE GROUP ACCIDENT
16 AND HEALTH INSURANCE COVERAGE

17 Revised Law

18 Sec. 1251.451. APPLICABILITY OF CERTAIN LAWS TO
19 OUT-OF-STATE GROUP ACCIDENT AND HEALTH INSURANCE COVERAGE. (a)
20 Chapters 1365 and 1368 and Subchapters A and C, Chapter 1451, apply
21 to:

22 (1) a certificate of insurance issued to a resident of
23 this state under a group accident and health insurance policy
24 delivered, issued for delivery, or renewed outside this state; or

25 (2) a certificate issued to a resident of this state
26 under a policy delivered, issued for delivery, or renewed outside
27 this state by a group hospital service corporation.

28 (b) Subsection (a) does not apply to a specified disease or
29 limited benefit policy. (V.T.I.C. Art. 3.51-12.)

30 Source Law

31 Art. 3.51-12. Articles 3.51-9, 21.35A, and 21.52
32 of this code and Section 2(G), Chapter 397, Acts of the
33 54th Legislature, 1955 (Article 3.70-2, Vernon's Texas
34 Insurance Code), apply to:

35 (1) a certificate of insurance issued to a
36 resident of this state under a group accident and
37 health insurance policy delivered, issued for
38 delivery, or renewed outside this state; or

39 (2) a certificate issued to a resident of

1 this state under a policy delivered, issued for
2 delivery, or renewed outside this state by a nonprofit
3 hospital and medical service plan corporation. This
4 article shall not apply to specified disease or
5 limited benefit policies.

6 Revisor's Note

7 V.T.I.C. Article 3.51-12 provides in part that
8 V.T.I.C. Article 21.35A applies to coverage under
9 certain out-of-state group accident and health
10 insurance policies. Article 3.51-12 was enacted by
11 Chapter 824, Acts of the 69th Legislature, Regular
12 Session, 1985, as Article 3.51-10. It was renumbered
13 as Article 3.51-12 by Section 5.01(a)(30), Chapter
14 167, Acts of the 70th Legislature, Regular Session,
15 1987. At the time the article was enacted, Vernon's
16 Texas Insurance Code included an Article 21.35A that
17 was enacted by Chapter 556, Acts of the 65th
18 Legislature, Regular Session, 1977, that provided that
19 if a group insurance policy covered psychological
20 services, an insured was entitled to obtain those
21 services from a medical doctor or psychologist. That
22 Article 21.35A was repealed by Section 11.91, Chapter
23 242, Acts of the 72nd Legislature, Regular Session,
24 1991. (A second Article 21.35A was enacted by Chapter
25 685, Acts of the 73rd Legislature, Regular Session,
26 1993, but it relates to charges imposed by a local
27 recording agent for obtaining certain records or
28 photographs in connection with an insured or an
29 applicant for insurance.) Accordingly, the revised
30 law omits the reference to Article 21.35A.

31 CHAPTER 1252. DISCONTINUATION AND REPLACEMENT OF GROUP
32 AND GROUP-TYPE HEALTH BENEFIT PLAN COVERAGE

33 SUBCHAPTER A. GENERAL PROVISIONS

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1 [Sections 1252.004-1252.100 reserved for expansion]

2 SUBCHAPTER B. DISCONTINUATION OF COVERAGE

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8 DISCONTINUED COVERAGE 744

9 [Sections 1252.105-1252.200 reserved for expansion]

10 SUBCHAPTER C. REPLACEMENT OF COVERAGE

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17 Sec. 1252.206. DETERMINATION OF BENEFITS AVAILABLE UNDER

18 REPLACED PLAN 748

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20 CHAPTER 1252. DISCONTINUATION AND REPLACEMENT OF GROUP

21 AND GROUP-TYPE HEALTH BENEFIT PLAN COVERAGE

22 SUBCHAPTER A. GENERAL PROVISIONS

23 Revised Law

24 Sec. 1252.001. DEFINITIONS. In this chapter:

25 (1) "Carrier" means:

26 (A) an insurer; or

27 (B) a group hospital service corporation
28 operating under Chapter 842.

29 (2) "Health benefit plan" means:

30 (A) any accident and health insurance policy;

31 (B) a subscriber contract of a group hospital
32 service corporation; or

33 (C) an accident and health benefits package of a
34 multiple employer trust that is not exempt from regulation by this

1 state as an employee welfare benefit plan under the Employee
2 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et
3 seq.), as amended.

4 (3) "Previous carrier" means a carrier whose health
5 benefit plan coverage has been replaced with health benefit plan
6 coverage provided by a succeeding carrier.

7 (4) "Succeeding carrier" means a carrier that replaces
8 the health benefit plan coverage provided by another carrier with
9 its own health benefit plan coverage.

10 (5) "Total disability" or "totally disabled" means:

11 (A) with respect to an employee or other primary
12 insured covered under a health benefit plan, the complete inability
13 of that individual to perform all of the substantial and material
14 duties and functions of the individual's occupation and any other
15 gainful occupation in which the individual earns substantially the
16 same compensation earned before the disability; and

17 (B) with respect to any other individual covered
18 under a health benefit plan, confinement as a bed patient in a
19 hospital. (V.T.I.C. Art. 3.51-6A, Secs. 1 (part); 2(b); 5(f);
20 6(b)(1), (3); New.)

21 Source Law

22 Art. 3.51-6A

23 Sec. 1. [This article is applicable to:]

24 (1) all accident and health insurance
25 policies, including subscriber contracts of a
26 nonprofit service corporation subject to Chapter 20 of
27 this code; and

28 (2) benefit packages of multiple employer
29 trusts which are not exempt from regulation by the
30 State of Texas as employee welfare benefit plans under
31 the Employee Retirement Income Security Act of 1974,
32 as amended (Public Law 93-406),

33 [Sec. 2]

34 (b) "Carrier" means any insurer, including a
35 nonprofit service corporation subject to Chapter 20 of
36 this code as specified in Section 1 of this article.

37 [Sec. 5]

38 (f) For the purposes of this section, the terms
39 "total disability" and "totally disabled" mean (1)
40 with respect to an employee or other primary insured
41 under the policy, the complete inability of the person
42 to perform all of the substantial and material duties
43 and functions of his or her occupation and any other
44 gainful occupation in which such person earns

1 substantially the same compensation earned prior to
2 disability, and (2) with respect to any other person
3 under the policy, confinement as a bed patient in a
4 hospital.

5 [Sec. 6]

6 (b) In this section:

7 (1) "Prior carrier" means an insurer
8 including a group hospital service corporation subject
9 to Chapter 20 of this code, whose coverage has been
10 replaced by a succeeding carrier.

11 (3) "Succeeding carrier" means an insurer
12 including a group hospital service corporation subject
13 to Chapter 20 of this code that has replaced the
14 coverage of a prior carrier with its coverage.

15 Revisor's Note

16 (1) Sections 1, 2(a)(3), and 2(b), V.T.I.C.
17 Article 3.51-6A, refer to a "nonprofit service
18 corporation" or "a nonprofit service corporation
19 subject to Chapter 20 of this code." The term most
20 frequently used to refer to such a corporation in
21 Chapter 20, revised as Chapter 842 of this code, is
22 "group hospital service corporation." Consequently,
23 throughout this chapter the revised law refers to
24 Chapter 842 and substitutes "group hospital service
25 corporation" for "nonprofit service corporation" to
26 provide for consistent use of terminology in this
27 code.

28 (2) The definition of "health benefit plan" is
29 added to the revised law for clarity and drafting
30 convenience. Although V.T.I.C. Article 3.51-6A
31 refers to "policies" and "policies or contracts," it
32 is clear from the context of Section 1 of that article
33 that in addition to insurance policies, the article
34 applies to subscriber contracts of group hospital
35 service corporations and benefit packages of certain
36 multiple employer trusts when referring to a plan of
37 health benefits. Consequently, for purposes of this
38 chapter, "health benefit plan" is a more accurate term
39 than "policy" and "policy or contract," and throughout
40 this chapter, the revised law substitutes "health

1 benefit plan" for "policy" and "policy or contract."

2 (3) Section 1, V.T.I.C. Article 3.51-6A, refers
3 to the applicability of this chapter to benefit
4 packages of certain multiple employer trusts. When
5 referring to those trusts in the definition of "health
6 benefit plan," the revised law adds "accident and
7 health" before the term "benefits packages" because it
8 is clear from the context of the source law that those
9 are the type of benefits packages to which this chapter
10 applies.

11 (4) Section 6(b)(2), V.T.I.C. Article 3.51-6A,
12 defines a "prior plan" and Section 6(b)(4), V.T.I.C.
13 Article 3.51-6A, defines a "succeeding carrier's
14 plan." The revised law omits the definitions as
15 unnecessary because the meaning of those terms is
16 clear in the context in which the terms appear. The
17 omitted law reads:

18 (2) "Prior plan" means the plan
19 of benefits of a prior carrier.

20 (4) "Succeeding carrier's plan"
21 means the plan of benefits of the succeeding
22 carrier.

23 Revised Law

24 Sec. 1252.002. APPLICABILITY OF CHAPTER. (a) This
25 chapter applies only to a health benefit plan that:

26 (1) provides coverage on a group or group-type basis
27 to an individual eligible for that coverage because of the
28 individual's status as:

29 (A) an employee of an employer; or

30 (B) a member of a labor union or a member of an
31 association; and

32 (2) is delivered or issued for delivery in this state.

33 (b) This chapter does not apply to an entity that is not
34 engaged in the business of insurance in this state. (V.T.I.C. Art.
35 3.51-6A, Sec. 1.)

1 omits the quoted language as unnecessary because if a
2 law does not apply to an entity, it cannot provide the
3 legal basis for a regulation arising from that law.

4 Revised Law

5 Sec. 1252.003. COVERAGE ISSUED ON GROUP-TYPE BASIS. (a)
6 For purposes of this chapter, health benefit plan coverage is
7 provided on a group-type basis if:

8 (1) the plan provides coverage under an insurance
9 policy or subscriber contract to a class of employees or a class of
10 members of a labor union or members of an association and the class
11 is determined by conditions relating to their employment or to
12 their membership in the union or association;

13 (2) coverage under the plan is not available to the
14 general public and can be obtained and maintained only because of
15 the covered individual's employment status or membership in a labor
16 union or an association;

17 (3) premiums or subscription charges for the plan are
18 paid to the carrier on an aggregate or bulk-payment basis; and

19 (4) the plan is sponsored by:

20 (A) the employer of the class of employees
21 covered by the plan; or

22 (B) the labor union or an association to which
23 the class of members covered by the plan belongs.

24 (b) Health benefit plan coverage is not provided on a
25 group-type basis if it is a salary-budget plan using individual
26 insurance policies or subscriber contracts that do not meet the
27 conditions for group-type coverage specified by Subsection (a).

28 (V.T.I.C. Art. 3.51-6A, Sec. 2(a).)

29 Source Law

30 Sec. 2. (a) "Group-type basis" means an
31 accident and health benefit plan that meets the
32 following conditions:

33 (1) insurance coverage is provided through
34 insurance policies or subscriber contracts to classes
35 of employees or members of a labor union or members of
36 an association, in which the classes are defined in
37 terms of conditions pertaining to employment or
38 membership;

1 (2) coverage is not available to the
2 general public and can be obtained and maintained only
3 because of the covered person's employment status or
4 membership in a labor union or an association;

5 (3) payment of premiums or subscription
6 charges is arranged on an aggregate or bulk-payment
7 basis to the insurer or nonprofit service corporation;
8 and

9 (4) the employer, union, or association
10 sponsors the plan. The term does not refer to a
11 salary-budget plan utilizing either individual
12 insurance policies or subscriber contracts that do not
13 meet the conditions specified in this subsection.

14 [Sections 1252.004-1252.100 reserved for expansion]

15 SUBCHAPTER B. DISCONTINUATION OF COVERAGE

16 Revised Law

17 Sec. 1252.101. NOTICE OF DISCONTINUATION OF COVERAGE. A
18 notice of discontinuation of a health benefit plan must include a
19 request to the group policyholder or other entity responsible for
20 making payments or submitting subscription charges to the carrier
21 to notify employees or members covered by the plan of the
22 discontinuation and the date of the discontinuation. (V.T.I.C.
23 Art. 3.51-6A, Sec. 4.)

24 Source Law

25 Sec. 4. A notice of discontinuance of the policy
26 or contract must include a request to the group
27 policyholder or other entity responsible for making
28 payments or submitting subscription charges to the
29 carrier for notification of employees covered under
30 the policy or contract of the date on which the policy
31 or contract will discontinue.

32 Revisor's Note

33 Section 4, V.T.I.C. Article 3.51-6A, refers to
34 "employees" covered under the policy or contract. The
35 revised law substitutes "employees or members" for
36 "employees" for consistency of terminology in this
37 chapter and because it is clear that members of a labor
38 union or association may be covered under a policy or
39 contract subject to this chapter. See Section
40 1252.002.

41 Revised Law

42 Sec. 1252.102. EXTENSION OF BENEFITS PROVISION;
43 EXEMPTION. (a) A health benefit plan must contain, subject to

1 this section and Section 1252.103, a reasonable provision providing
2 for an extension of benefits for a total disability that exists on
3 the date of the plan's discontinuation.

4 (b) A health benefit plan must contain a reasonable
5 extension of benefits provision for coverage for hospital or
6 medical expenses other than dental expenses. A provision is
7 considered reasonable if it provides to an individual who is
8 covered under the plan and who is totally disabled on the date of
9 the plan's discontinuation an extension of benefits for expenses
10 incurred in treating the condition causing the total disability and
11 the extension is provided for at least the lesser of:

12 (1) 90 days; or

13 (2) the duration of the total disability.

14 (c) An extension of benefits provision required under this
15 section may provide for an exclusion from coverage for an
16 individual whose coverage is being discontinued and replaced with
17 coverage that:

18 (1) is provided by a succeeding carrier; and

19 (2) provides a level of benefits that is at least
20 substantially equal to the level of benefits provided under the
21 replaced health benefit plan.

22 (d) An applicable extension of benefits provision must be
23 described in the policy or contract and the group insurance
24 certificate.

25 (e) Benefits payable during an extension period may be
26 subject to the regular benefit limits of the health benefit plan.

27 (f) This section does not apply to a health benefit plan
28 that was delivered or issued for delivery in this state before
29 January 1, 1982, and whose level of benefits has not been modified
30 after December 31, 1981. (V.T.I.C. Art. 3.51-6A, Secs. 5(a), (c),
31 (d), (e).)

32 Source Law

33 Sec. 5. (a) Every policy or other contract
34 subject to this article delivered or issued for
35 delivery in this state or under which the level of

1 benefits is altered, modified, or amended, on or after
2 the date this article takes effect, must contain a
3 reasonable provision for extension of benefits in the
4 event of total disability at the date of
5 discontinuance of the group policy or contract. The
6 provision must at a minimum comply with this section.

7 (c) In the case of hospital or medical expense
8 coverages other than dental expense coverages, a
9 reasonable extension of benefits provision must be
10 included. The provision is considered reasonable if
11 it provides an extension of benefits for any person
12 under the policy who is totally disabled at the date of
13 discontinuance of the group policy or contract at
14 least for the period of such total disability or for 90
15 days, whichever is less, for expenses for treatment of
16 the condition causing such total disability.

17 (d) Any applicable extension of benefits must be
18 described in the policies, contracts, and group
19 insurance certificates. The benefits payable during
20 any period of extension may be subject to the regular
21 benefit limits of the policy or contract.

22 (e) Any extension of benefits provision under
23 this Section 5 may provide that the extension of
24 benefits are not applicable to any person whose
25 coverage under the group policy or contract being
26 discontinued is replaced by coverage with a succeeding
27 carrier as defined in Section 6 of this article
28 providing substantially equivalent or greater
29 benefits than those provided by the discontinued
30 policy or contract.

31 Revisor's Note

32 (1) Section 5(a), V.T.I.C. Article 3.51-6A,
33 refers to a "policy that is altered, modified, or
34 amended." The revised law omits the references to
35 "altered" and "amended" because those terms are
36 included within the meaning of "modified."

37 (2) Section 5(a), V.T.I.C. Article 3.51-6A,
38 refers to "on or after the date this article takes
39 effect." The effective date of Article 3.51-6A was
40 January 1, 1982. For clarity, the revised law refers
41 to "January 1, 1982" and "after December 31, 1981."

42 Revised Law

43 Sec. 1252.103. INDEMNITY OR BENEFITS PAYABLE FOR
44 DISABILITY. A discontinuation of health benefit plan coverage
45 occurring during a period of disability does not affect:

46 (1) any benefits payable under the plan for loss of
47 time from work because of the disability; or

48 (2) any specific indemnity required to be provided

1 under the plan during a period of hospital confinement. (V.T.I.C.
2 Art. 3.51-6A, Sec. 5(b).)

3 Source Law

4 (b) In a group or group-type basis coverage
5 providing benefits for loss of time from work or
6 specific indemnity during hospital confinement,
7 discontinuance of the policy during a disability does
8 not discontinue or otherwise affect the benefits
9 payable for that disability or confinement.

10 Revised Law

11 Sec. 1252.104. LIABILITY FOR LOSS UNDER AUTOMATICALLY
12 DISCONTINUED COVERAGE. (a) If a health benefit plan provides for
13 automatic discontinuation of coverage when a premium or
14 subscription charge due under the plan is not paid before the
15 expiration of a grace period specified in the plan for that payment,
16 the carrier or other entity responsible for making premium payments
17 or for submitting premiums or subscription charges to the carrier
18 is liable, on the submission of a valid claim, for a loss that is:

- 19 (1) covered by the plan; and
20 (2) incurred before the expiration of the grace
21 period.

22 (b) The commissioner may adopt reasonable rules necessary
23 to implement this section. (V.T.I.C. Art. 3.51-6A, Sec. 3.)

24 Source Law

25 Sec. 3. If a policy or contract subject to this
26 article provides a grace period for payment of
27 premiums or subscription charges and for automatic
28 discontinuance of the policy or contract after a
29 premium or subscription charge has remained unpaid
30 through the grace period allowed for that payment, the
31 carrier or other entity responsible for making
32 payments or submitting subscription charges or
33 premiums to the carrier is liable for valid claims for
34 covered losses incurred before the end of the grace
35 period. The State Board of Insurance may adopt
36 reasonable rules that are necessary to implement this
37 section.

38 Revisor's Note

39 Section 3, V.T.I.C. Article 3.51-6A, refers to
40 the State Board of Insurance. Chapter 685, Acts of the
41 73rd Legislature, Regular Session, 1993, abolished the
42 State Board of Insurance and transferred its functions

1 to the commissioner of insurance and the Texas
2 Department of Insurance. Consequently, the reference
3 to the board has been changed appropriately.

4 [Sections 1252.105-1252.200 reserved for expansion]

5 SUBCHAPTER C. REPLACEMENT OF COVERAGE

6 Revised Law

7 Sec. 1252.201. TOTAL DISABILITY STATUS. In this
8 subchapter, a reference to the total disability status of an
9 individual means the individual's disability status immediately
10 preceding the date on which the succeeding carrier's coverage takes
11 effect. (V.T.I.C. Art. 3.51-6A, Sec. 6(c).)

12 Source Law

13 (c) In this section, any reference to an
14 individual who was or was not totally disabled means
15 the individual's status immediately before the date
16 the succeeding carrier's coverage becomes effective.

17 Revised Law

18 Sec. 1252.202. EFFECTIVE DATE OF COVERAGE UNDER REPLACEMENT
19 PLAN. (a) An individual who was covered by a previous carrier's
20 health benefit plan on the date on which that plan was discontinued
21 shall be provided coverage under the succeeding carrier's health
22 benefit plan as of the replacement plan's effective date if the
23 individual:

24 (1) is eligible for coverage because the individual is
25 a member of a class eligible for coverage under the replacement plan
26 and satisfies the replacement plan's actively at work and
27 nonconfinement requirements; and

28 (2) elects to be covered under the replacement plan.

29 (b) An individual who would be covered by the succeeding
30 carrier under Subsection (a) but who does not satisfy the
31 replacement plan's actively at work and nonconfinement
32 requirements shall be covered under the replacement plan when the
33 individual satisfies those requirements. (V.T.I.C. Art. 3.51-6A,
34 Sec. 6(e).)

1 Source Law

2 (e) Any person covered under the prior plan on
3 its date of discontinuance who is eligible for
4 coverage in accordance with the succeeding carrier's
5 plan of benefits, in respect of classes eligible and
6 actively at work and nonconfinement rules and who
7 elects such coverage shall be covered under the
8 succeeding carrier's plan on its effective date;
9 provided that any person who would have been covered
10 under the succeeding provisions of this subsection but
11 for the actively at work or nonconfinement rules shall
12 become covered under the succeeding carrier's plan
13 when such person satisfied such actively at work and
14 nonconfinement rules.

15 Revised Law

16 Sec. 1252.203. EXTENSION OF BENEFITS FOR TOTAL
17 DISABILITY. (a) With respect to providing a type of coverage for
18 which Section 1252.102 requires an extension of benefits for an
19 individual with a total disability, a succeeding carrier replacing
20 a previous carrier's plan that is not subject to that section must
21 provide, subject to Subsection (b), the lesser of:

22 (1) extended benefit coverage that the previous
23 carrier would have been required to provide under Section 1252.102
24 if the previous carrier had been subject to that section; or

25 (2) extended benefit coverage that the succeeding
26 carrier is required to provide under Section 1252.102.

27 (b) The extended benefit coverage may be reduced by any
28 benefits actually payable under the previous carrier's health
29 benefit plan. (V.T.I.C. Art. 3.51-6A, Sec. 6(f).)

30 Source Law

31 (f) When replacing a prior carrier's plan which
32 is not subject to Section 5 of this article, the
33 succeeding carrier's plan, in the case of a type of
34 coverage for which Section 5 of this article requires
35 an extension of benefits for a person who is totally
36 disabled shall provide the lesser of (1) the extension
37 of benefits which would have been required by the prior
38 carrier's plan under Section 5, or (2) the extension of
39 benefits required for the succeeding carrier's plan;
40 provided, any such benefits may be reduced by any
41 benefits actually payable under the prior carrier's
42 plan.

43 Revised Law

44 Sec. 1252.204. COVERAGE FOR PREEXISTING CONDITIONS. (a) A
45 succeeding carrier's health benefit plan that limits coverage in
46 accordance with a preexisting conditions provision, other than a

1 waiting period, must provide, during the period the limitation on
2 coverage is in effect, the level of benefits prescribed by this
3 section to an individual covered by the succeeding carrier who:

4 (1) has a preexisting condition; and

5 (2) was covered by the previous carrier's plan on the
6 date on which that plan was discontinued.

7 (b) The health benefit plan must provide a level of benefits
8 equal to the lesser of:

9 (1) the level of benefits available under the
10 succeeding carrier's plan as determined without applying the
11 preexisting conditions provision; or

12 (2) the level of benefits that would have been
13 available under the previous carrier's plan. (V.T.I.C. Art.
14 3.51-6A, Sec. 6(g).)

15 Source Law

16 (g) If there is a preexisting conditions
17 limitation, other than a waiting period, included in
18 the succeeding carrier's plan, the level of benefits
19 applicable to preexisting conditions of persons
20 becoming covered in accordance with this subsection by
21 the succeeding carrier's plan and who were covered
22 under the prior plan on the date of discontinuance of
23 the prior plan during the period of time the limitation
24 applies under the succeeding carrier's plan shall be
25 the lesser of:

26 (1) the benefits of the succeeding
27 carrier's plan determined without application of the
28 preexisting conditions limitation; or

29 (2) the benefits of the prior plan.

30 Revised Law

31 Sec. 1252.205. WAITING PERIOD. If the benefits that were
32 available under a previous carrier's health benefit plan are
33 similar to the benefits available under a succeeding carrier's
34 health benefit plan, the succeeding carrier shall give credit for
35 the satisfaction or partial satisfaction of any waiting period or
36 similar provision that has been satisfied under the previous
37 carrier's plan. (V.T.I.C. Art. 3.51-6A, Sec. 6(h) (part).)

38 Source Law

39 (h) The succeeding carrier, in applying any
40 waiting periods in its plan, shall give credit for the
41 satisfaction or partial satisfaction of same or
42 similar provisions under a prior plan providing

1 similar benefits.

2

3 Revised Law

4 Sec. 1252.206. DETERMINATION OF BENEFITS AVAILABLE UNDER
5 REPLACED PLAN. (a) If a succeeding carrier requires a
6 determination of the benefits available under the previous
7 carrier's health benefit plan, the previous carrier shall provide
8 at the request of the succeeding carrier:

9 (1) a statement of the benefits available under the
10 previous carrier's plan; or

11 (2) pertinent information sufficient either to allow
12 verification of those benefits or to allow the succeeding carrier
13 to make a determination of those benefits.

14 (b) A determination of benefits under this section must be
15 made using the definitions of, and in accordance with all of the
16 conditions and covered expense provisions of, the previous
17 carrier's plan as if that plan had not been replaced. (V.T.I.C.
18 Art. 3.51-6A, Sec. 6(h) (part).)

19 Source Law

20 (h)

21 If a determination of the benefits of the prior
22 plan is required by the succeeding carrier, the prior
23 carrier shall, at the succeeding carrier's request,
24 furnish a statement of the benefits available or
25 pertinent information sufficient either to permit
26 verification of the benefits available under the prior
27 plan or to permit the determination of the benefits by
28 the succeeding carrier. For the purposes of this
29 subsection, benefits of the prior plan are determined
30 in accordance with all of the definitions, conditions,
31 and covered expense provisions of the prior plan and
32 not the succeeding carrier's plan. The benefit
33 determination is made as if the prior plan had not been
34 replaced by the succeeding carrier.

35 Revised Law

36 Sec. 1252.207. LIABILITY OF PREVIOUS CARRIER. A carrier of
37 a health benefit plan that is being discontinued is liable only for
38 any accrued liabilities regarding the plan and for any extension of
39 benefits provided under the plan, regardless of whether the group
40 policyholder or any other entity responsible for making payments or
41 for submitting subscription charges to the carrier:

42 (1) replaces the coverage provided under the

1 discontinued plan with health benefit plan coverage provided by
2 another carrier;

3 (2) self-insures a health benefit plan; or

4 (3) does not provide health benefit plan coverage.

5 (V.T.I.C. Art. 3.51-6A, Sec. 6(d).)

6 Source Law

7 (d) The prior carrier is liable only to the
8 extent of its accrued liabilities and extensions of
9 benefits, regardless of whether the group policyholder
10 or other entity responsible for making payments or
11 submitting subscription charges to the carrier secures
12 replacement coverage from a new carrier, self-insures,
13 or foregoes the provision of coverage.

14 Revisor's Note
15 (End of Subchapter)

16 The revised law omits as unnecessary Section
17 6(a), V.T.I.C. Article 3.51-6A, which states that
18 Section 6 governs determination of carrier liability
19 when a carrier's health benefit plan replaces another
20 health benefit plan providing similar benefits.
21 Provisions relating to carrier liability requirements
22 to which Section 6 refers are revised in this
23 subchapter and establish those requirements without an
24 additional reference to them in this subchapter. The
25 omitted law reads:

26 Sec. 6. (a) This section applies to
27 determination of the carrier responsible
28 for liability in those instances in which
29 one carrier's plan of benefits replaces a
30 plan of similar benefits of another.

31 CHAPTER 1253. CANCELLATION OF GROUP COVERAGE IN
32 CERTAIN CIRCUMSTANCES

33 SUBCHAPTER A. GENERAL PROVISIONS

34 Sec. 1253.001. LIMITATION OF SERVICES AND BENEFITS ON

35 CONTRACT RENEGOTIATION 750

36 [Sections 1253.002-1253.050 reserved for expansion]

37 SUBCHAPTER B. CONTINUATION OF GROUP ACCIDENT AND HEALTH

38 INSURANCE POLICIES DURING LABOR DISPUTE

39 Sec. 1253.051. APPLICABILITY OF SUBCHAPTER 752

1 Sec. 1253.052. CONTINUATION OF GROUP ACCIDENT AND HEALTH
2 INSURANCE DURING LABOR DISPUTE REQUIRED
3 FOR CERTAIN POLICIES 752
4 Sec. 1253.053. CONTRIBUTIONS IF POLICYHOLDER IS TRUSTEE . . . 753
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14 CHAPTER 1253. CANCELLATION OF GROUP COVERAGE IN CERTAIN
15 CIRCUMSTANCES

16 SUBCHAPTER A. GENERAL PROVISIONS

17 Revised Law

18 Sec. 1253.001. LIMITATION OF SERVICES AND BENEFITS ON
19 CONTRACT RENEGOTIATION. (a) In this section, "health benefit
20 contract" means a contract providing group health care coverage for
21 employees that is delivered, issued for delivery, or renewed in
22 this state by:

- 23 (1) an insurance company;
- 24 (2) a group hospital service corporation operating
25 under Chapter 842; or
- 26 (3) a health maintenance organization operating under
27 Chapter 843.

28 (b) Subject to Subsection (c), if an employer in this state
29 agrees to renegotiate a health benefit contract, a change in the
30 renegotiated contract may not operate solely to terminate
31 eligibility with respect to any member of the group who, before the
32 contract was renegotiated:

- 33 (1) was covered under the contract; and
- 34 (2) had a sickness or injury for which a service was

1 being provided or a benefit was being paid under the contract.

2 (c) A renegotiated health benefit contract may include a
3 different durational or dollar limit or a different deductible
4 amount or amount of coinsurance applicable to a sickness or injury
5 for which a service was being provided or benefit was being paid
6 before the contract was renegotiated if that same or a similar limit
7 or amount applies to a service provided or benefit paid for a
8 similar sickness or a related condition or injury covered by the
9 contract. (V.T.I.C. Art. 3.51-6C.)

10 Source Law

11 Art. 3.51-6C. (a) In this article, "health
12 insurance contract" means a group health insurance
13 contract providing health care coverage for employees
14 delivered, issued for delivery, or renewed in this
15 state by an insurance company, including a group
16 hospital service corporation under Chapter 20 of this
17 code and a health maintenance organization under the
18 Texas Health Maintenance Organization Act (Chapter
19 20A, Vernon's Texas Insurance Code).

20 (b) If an employer in this state agrees to
21 renegotiate a health insurance contract through which
22 coverage is provided to his employees, subject to
23 Subsection (c) of this article, any changes in the
24 renegotiated contract may not operate solely to
25 terminate eligibility as to any member of the group
26 with coverage under the contract before the
27 renegotiation for a sickness or injury for which
28 services were being provided or benefits were being
29 paid before renegotiation.

30 (c) A renegotiated health insurance contract
31 may include any amended or renegotiated durational
32 limits, dollar limits, deductibles, or coinsurance
33 covering services or benefits under Subsection (b) of
34 this article if those same or similar limits apply to
35 similar sicknesses or related conditions and injuries
36 covered by the health insurance contract.

37 Revisor's Note

38 Section (a), V.T.I.C. Article 3.51-6C, defines
39 "health insurance contract." "Insurance contract" is
40 a term used in conjunction with traditional insurance.
41 Included within the definition of "health insurance
42 contract" are group contracts issued by health
43 maintenance organizations. The coverage provided by
44 this type of document is not insurance coverage, and
45 this type of coverage document is not typically
46 described as an "insurance contract." Therefore,

1 "health benefit contract" is a more accurate term than
2 "health insurance contract," and the revised law
3 substitutes "health benefit contract" for "health
4 insurance contract."

5 [Sections 1253.002-1253.050 reserved for expansion]

6 SUBCHAPTER B. CONTINUATION OF GROUP ACCIDENT AND HEALTH
7 INSURANCE POLICIES DURING LABOR DISPUTE

8 Revised Law

9 Sec. 1253.051. APPLICABILITY OF SUBCHAPTER. This
10 subchapter applies to a group accident and health insurance policy
11 that is delivered or issued for delivery in this state and as to
12 which any part of the premium is paid or is to be paid by an employer
13 under the terms of a collective bargaining agreement. (V.T.I.C.
14 Art. 3.51-8 (part), as amended Acts 77th Leg., R.S., Ch. 1419.)

15 Source Law

16 Art. 3.51-8. [No] group accident and health
17 insurance policy shall be delivered or issued for
18 delivery in this state where the premiums or any part
19 thereof is paid or is to be paid in whole or in part by
20 an employer pursuant to the terms of a collective
21 bargaining agreement

22 Revised Law

23 Sec. 1253.052. CONTINUATION OF GROUP ACCIDENT AND HEALTH
24 INSURANCE DURING LABOR DISPUTE REQUIRED FOR CERTAIN POLICIES. An
25 insurer may not deliver or issue for delivery a policy subject to
26 this subchapter unless the policy provides that if the employees
27 covered by the policy stop work because of a labor dispute, coverage
28 continues under the policy, on timely payment of the premium, for
29 each employee who:

30 (1) is covered under the policy on the date the work
31 stoppage begins;

32 (2) continues to pay the employee's individual
33 contribution, subject to the conditions provided by this
34 subchapter; and

35 (3) assumes and pays during the work stoppage the
36 contribution due from the employer, subject to the conditions

1 provided by this subchapter. (V.T.I.C. Art. 3.51-8 (part), as
2 amended Acts 77th Leg., R.S., Ch. 1419.)

3 Source Law

4 Art. 3.51-8. No group accident and health
5 insurance policy shall be delivered or issued for
6 delivery . . . unless the policy provides that in the
7 event of a cessation of work by the employees covered
8 by the policy as the result of a labor dispute, the
9 policy upon timely payment of the premium shall
10 continue in effect with respect to all employees
11 insured by the policy on the date of the cessation of
12 work who continue to pay their individual contribution
13 and who assume and pay the contribution due from the
14 employer for the period of cessation of work, under the
15 following conditions:
16 . . .

17 Revised Law

18 Sec. 1253.053. CONTRIBUTIONS IF POLICYHOLDER IS TRUSTEE.

19 (a) An employee's contribution for purposes of a policy as to which
20 the policyholder is a trustee or the trustees of a fund established
21 or maintained wholly or partly by the employer is the amount the
22 employee and employer would have been required to contribute to the
23 fund for the employee if:

24 (1) the work stoppage had not occurred; and

25 (2) the agreement requiring the employer to make
26 contributions to the fund were in effect.

27 (b) The policy may provide that continuation of coverage is
28 contingent on the collection of individual contributions by the
29 policyholder or the policyholder's agent. (V.T.I.C. Art. 3.51-8,
30 Subdivs. (b), (c) (part).)

31 Source Law

32 (b) If the policyholder is a trustee or the
33 trustees of a fund established or maintained in whole
34 or in part by the employer, the employee's contribution
35 shall be the amount which he and his employer would
36 have been required to contribute to the trust for such
37 employee if (1) the cessation of work had not occurred
38 and (2) the agreement requiring the employer to make
39 contributions to the trust were in full force.

40 (c) The policy may provide that the
41 continuation of insurance is contingent upon the
42 collection of individual contributions . . . by the
43 policyholder or the policyholder's agent with respect
44 to policies referred to in Subdivision (b) above.

45 Revised Law

46 Sec. 1253.054. CONTRIBUTIONS IF POLICYHOLDER IS NOT

1 TRUSTEE. (a) A policy as to which the policyholder is not a
2 trustee or the trustees of a fund established or maintained in whole
3 or in part by the employer must provide that the employee's
4 individual contribution:

5 (1) is the policy rate applicable:

6 (A) on the date the work stoppage begins; and

7 (B) to an individual in the class to which the
8 employee belongs as provided by the policy; or

9 (2) if the policy does not provide for a rate
10 applicable to an individual, is an amount equal to the amount
11 determined by dividing:

12 (A) the total monthly premium in effect under the
13 policy on the date the work stoppage begins; by

14 (B) the total number of insureds under the policy
15 on that date.

16 (b) The policy may provide that continuation of coverage
17 under this subchapter is contingent on the collection of individual
18 contributions by the union or unions representing the employees.
19 (V.T.I.C. Art. 3.51-8, Subdivs. (a), (c) (part).)

20 Source Law

21 (a) If the policyholder is not a trustee or
22 the trustees of a fund established or maintained in
23 whole or in part by the employer, the policy shall
24 provide that the employee's individual contribution
25 shall be the rate in the policy, on the date cessation
26 of work occurs, applicable to an individual in the
27 class to which the employee belongs as set forth in the
28 policy. If the policy does not provide for a rate
29 applicable to individuals, the policy shall provide
30 that the employee's individual contribution shall be
31 an amount equal to the amount determined by dividing
32 (1) the total monthly premium in effect under the
33 policy at the date of cessation of work by (2) the
34 total number of persons insured under the policy at
35 such date.

36 (c) The policy may provide that the
37 continuation of insurance is contingent upon the
38 collection of individual contributions by the union or
39 unions representing the employees for policies
40 referred to in Subdivision (a) above and

41 Revised Law

42 Sec. 1253.055. PAYMENT OF CONTRIBUTION AND PREMIUM. A
43 policy may provide that continuation of coverage for an employee

1 under the policy is contingent on timely payment of:

2 (1) contributions by the employee; and

3 (2) the premium by the entity responsible for
4 collecting the individual employee contributions. (V.T.I.C.
5 Art. 3.51-8, Subdiv. (d).)

6 Source Law

7 (d) The policy may provide that the
8 continuation of insurance on each employee is
9 contingent upon timely payment of contributions by the
10 individual and timely payment of the premium by the
11 entity responsible for collecting the individual
12 contributions.

13 Revised Law

14 Sec. 1253.056. PAST DUE PREMIUM. (a) A policy may provide
15 that the continuation of coverage is contingent on payment of any
16 premium that:

17 (1) is unpaid on the date the work stoppage begins; and

18 (2) became due before the date the work stoppage
19 begins.

20 (b) A premium described by Subsection (a) must be paid
21 before the date the next premium becomes due under the policy.
22 (V.T.I.C. Art. 3.51-8, Subdiv. (h).)

23 Source Law

24 (h) The policy may provide that, if a
25 premium is unpaid at the date of cessation of work and
26 such premium became due prior to such cessation of
27 work, the continuation of insurance is contingent upon
28 payment of such premium prior to the date the next
29 premium becomes due under the terms of the policy.

30 Revised Law

31 Sec. 1253.057. INDIVIDUAL PREMIUM RATE INCREASE. (a) A
32 policy may provide that, during the period of a work stoppage, each
33 individual premium rate shall be increased by an amount not to
34 exceed 20 percent of the amount shown in the policy, or a greater
35 percentage as approved by the commissioner, to provide sufficient
36 compensation to the insurer to cover increased:

37 (1) administrative costs; and

38 (2) mortality and morbidity.

39 (b) If a policy provides for a premium rate increase in

1 accordance with this section, the amount of an employee's
2 contribution must be increased by the same percentage. (V.T.I.C.
3 Art. 3.51-8, Subdiv. (e).)

4 Source Law

5 (e) The policy may provide that each
6 individual premium rate shall be increased by any
7 amount up to 20 percent, or any higher percent which
8 may be approved by the commissioner, of that otherwise
9 shown in the policy during the period of cessation of
10 work in order to provide sufficient compensation to
11 the insurer to cover increased administrative costs
12 and increased mortality and morbidity. If the policy
13 does provide for such an increase, this shall have the
14 effect of increasing the employee's contribution by a
15 like percent.

16 Revised Law

17 Sec. 1253.058. PREMIUM RATE CHANGE NOT LIMITED. (a) This
18 subchapter does not limit any right of the insurer under a policy to
19 increase or decrease a premium rate before, during, or after a work
20 stoppage if the insurer would be entitled to increase the premium
21 rate had a work stoppage not occurred.

22 (b) A change in a premium rate made in accordance with this
23 section takes effect on a date that is determined by the insurer in
24 accordance with the terms of the policy. (V.T.I.C. Art. 3.51-8,
25 Subdiv. (f).)

26 Source Law

27 (f) Nothing in this article shall be
28 deemed to limit any right which the insurer may have in
29 accordance with the terms of the policy to increase or
30 decrease the premium rates before, during, or after
31 such cessation of work if in fact the insurer would
32 have had the right to increase the premium rate had the
33 cessation of work not occurred. If such a premium rate
34 change is made, it shall be effective, notwithstanding
35 any other provisions of this article, on such date as
36 the insurer shall determine in accordance with the
37 terms of the policy.

38 Revised Law

39 Sec. 1253.059. LIMITATIONS ON CONTINUATION OF COVERAGE.
40 This subchapter does not require the continuation of coverage under
41 a policy for any loss of time benefits included in the policy or the
42 continuation of other coverage for a period:

43 (1) longer than six months after a work stoppage
44 occurs;

1 (2) beyond the time that 75 percent of the covered
2 employees continue the coverage; or

3 (3) as to an individual covered employee, beyond the
4 time that the employee takes a full-time job with another employer.
5 (V.T.I.C. Art. 3.51-8, Subdiv. (i).)

6 Source Law

7 (i) Nothing herein shall be deemed to
8 require the continuation of any loss of time payments
9 included in any such group accident and health
10 insurance policy, nor of any other coverages beyond
11 the time that 75 percent of the employees continue such
12 coverage or as to any individual employee beyond the
13 time that he takes full-time employment with another
14 employer; nor shall anything herein be deemed to
15 require continuation of coverage more than six months
16 after the cessation of work.

17 Revised Law

18 Sec. 1253.060. OTHER PROVISIONS; COMMISSIONER APPROVAL
19 REQUIRED. A policy may contain any other provision relating to
20 continuation of policy coverage during a work stoppage that the
21 commissioner approves. (V.T.I.C. Art. 3.51-8, Subdiv. (g).)

22 Source Law

23 (g) The policy may contain such other
24 provisions with respect to such continuation of
25 insurance as the Commissioner of Insurance may
26 approve.

27 CHAPTER 1254. NOTICE OF RATE INCREASE FOR GROUP HEALTH
28 AND ACCIDENT COVERAGE

29 Sec. 1254.001. NOTICE OF RATE INCREASE 757

30 CHAPTER 1254. NOTICE OF RATE INCREASE FOR GROUP HEALTH
31 AND ACCIDENT COVERAGE

32 Revised Law

33 Sec. 1254.001. NOTICE OF RATE INCREASE. (a) In this
34 section, "insurer" means:

- 35 (1) a life insurance company;
- 36 (2) a health insurance company;
- 37 (3) an accident insurance company;
- 38 (4) a general casualty company;
- 39 (5) a mutual life insurance company or other mutual
40 insurance company;

1 (6) a mutual or natural premium life insurance
2 company;

3 (7) a Lloyd's plan;

4 (8) a reciprocal or interinsurance exchange;

5 (9) a fraternal benefit society;

6 (10) a local mutual aid association; or

7 (11) a group hospital service corporation.

8 (b) Not later than the 31st day before the date on which a
9 premium rate increase takes effect on a group policy of health
10 insurance, accident and health insurance, or life, health, and
11 accident insurance delivered or issued for delivery in this state
12 by an insurer, the insurer shall give written notice to the
13 policyholder of:

14 (1) the amount of the increase; and

15 (2) the date on which the increase is to take effect.

16 (c) A health maintenance organization shall give notice of
17 an increase in subscriber charges and service fees under a group
18 contract or coverage in the same manner as is required of an insurer
19 under Subsection (b).

20 (d) An insurer that issues a group policy described by
21 Subsection (b) to a multiple employer trust shall give the notice
22 required by that subsection to the trustee or group policyholder.

23 (e) The notice required by this section must be based on
24 coverage in effect on the date of the notice.

25 (f) This section may not be construed to prevent an insurer
26 or health maintenance organization, at the request of a
27 policyholder or contract holder, from negotiating a change in
28 benefits or rates after delivery of the notice required by this
29 section. (V.T.I.C. Art. 3.51-10, as amended Acts 77th Leg., R.S.,
30 Ch. 1419.)

31 Source Law

32 Art. 3.51-10. Not less than 30 days before the
33 date on which a premium rate increase takes effect on a
34 group policy of health, accident and health, or life,
35 health, and accident insurance delivered or issued for
36 delivery in this state by a life, accident, health or

1 casualty insurance company, mutual life insurance
2 company, mutual insurance company other than life,
3 mutual or natural premium life insurance company,
4 general casualty company, Lloyds, reciprocal or
5 interinsurance exchange, fraternal benefit society,
6 group hospitalization service insurer, or local mutual
7 aid association, the insurer shall give written notice
8 of the premium rate increase to the policyholder or in
9 the instance of a multiple employer trust to the
10 trustee or group policyholder of the amount of such
11 increase and the date on which the increase is to take
12 effect. Such notice is also required for increases in
13 subscriber charges and service fees under group
14 policies or contracts or coverage provided by health
15 maintenance organizations. Notice shall be based upon
16 coverages in effect on the date of the notice and
17 nothing contained herein shall be construed to prevent
18 the insurer or health maintenance organization from
19 negotiating changes in benefits and/or rates at the
20 request of the policyholder after the required notice
21 has been delivered.

22 Revisor's Note

23 (1) V.T.I.C. Article 3.51-10 refers to a "group
24 hospitalization service insurer." The term most
25 frequently used to refer to such an entity is "group
26 hospital service corporation." Consequently, the
27 revised law substitutes "group hospital service
28 corporation" for "group hospitalization service
29 insurer" to provide for consistent use of terminology
30 throughout this code.

31 (2) V.T.I.C. Article 3.51-10 refers in the
32 second sentence to "group policies or contracts or
33 coverage provided by health maintenance
34 organizations." The revised law omits the reference
35 to "policies" because that term is not necessary and is
36 not appropriately used in connection with coverage
37 provided by a health maintenance organization.
38 Similarly, the third sentence of V.T.I.C. Article
39 3.51-10 refers to the authority of an insurer or health
40 maintenance organization to negotiate changes in
41 benefits or rates at the request of "the
42 policyholder." The revised law adds a reference to
43 "contract holder" to reflect the appropriate term used
44 in connection with coverage provided by a health

1 maintenance organization.

2 [Chapters 1255-1270 reserved for expansion]

3 SUBTITLE C. MANAGED CARE

4 CHAPTER 1271. BENEFITS PROVIDED BY HEALTH MAINTENANCE

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25 STATEMENTS PROHIBITED 777

26 [Sections 1271.057-1271.100 reserved for expansion]

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10 [Sections 1271.157-1271.200 reserved for expansion]

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6 SUBCHAPTER A. GENERAL PROVISIONS

7 Revised Law

8 Sec. 1271.001. APPLICABILITY OF DEFINITIONS. In this
9 chapter, terms defined by Section 843.002 have the meanings
10 assigned by that section. (V.T.I.C. Art. 20A.01B, as added Acts
11 77th Leg., R.S., Ch. 1419.)

12 Source Law

13 Art. 20A.01B. In this Act, terms defined by
14 Section 843.002, Insurance Code, have the meanings
15 assigned by that section.

16 Revised Law

17 Sec. 1271.002. RIGHT TO EVIDENCE OF COVERAGE; ISSUANCE.

18 (a) Each enrollee residing in this state is entitled to evidence of
19 coverage under a health care plan.

20 (b) The health maintenance organization shall issue the
21 evidence of coverage, except as provided by Subsection (c).

22 (c) If the enrollee obtains coverage under a health care
23 plan through an insurance policy or a contract issued by a group
24 hospital service corporation, whether by option or otherwise, the
25 insurer or the group hospital service corporation shall issue the
26 evidence of coverage. (V.T.I.C. Art. 20A.09, Secs. (a), as amended
27 Acts 75th Leg., R.S., Ch. 905; (a)(1), as amended Acts 75th Leg.,
28 R.S., Ch. 1026.)

29 Source Law

30 Art. 20A.09. (a) [as amended Acts 75th Leg.,
31 R.S., Ch. 905] Every enrollee residing in this state is
32 entitled to evidence of coverage under a health care
33 plan. If the enrollee obtains coverage under a health
34 care plan through an insurance policy or a contract
35 issued by a group hospital service corporation,
36 whether by option or otherwise, the insurer or the
37 group hospital service corporation shall issue the
38 evidence of coverage. Otherwise, the health
39 maintenance organization shall issue the evidence of
40 coverage.

1 Art. 20A.09. (a)(1) [as amended Acts 75th Leg.,
2 R.S., Ch. 1026] Every enrollee residing in this state
3 is entitled to evidence of coverage under a health care
4 plan. If the enrollee obtains coverage under a health
5 care plan through an insurance policy or a contract
6 issued by a group hospital service corporation,
7 whether by option or otherwise, the insurer or the
8 group hospital service corporation shall issue the
9 evidence of coverage. Otherwise, the health
10 maintenance organization shall issue the evidence of
11 coverage.

12 Revised Law

13 Sec. 1271.003. EVIDENCE OF COVERAGE NOT HEALTH INSURANCE
14 POLICY. An evidence of coverage is not a health insurance policy
15 as that term is defined by this code. (V.T.I.C. Art. 20A.09, Secs.
16 (o), as amended Acts 75th Leg., R.S., Ch. 905; (g), as amended Acts
17 75th Leg., R.S., Ch. 1026.)

18 Source Law

19 (o) [as amended Acts 75th Leg., R.S., Ch. 905]
20 Evidence of coverage does not constitute a health
21 insurance policy as that term is defined by the
22 Insurance Code.

23 (g) [as amended Acts 75th Leg., R.S., Ch. 1026]
24 Evidence of coverage does not constitute a health
25 insurance policy as that term is defined by the
26 Insurance Code.

27 Revised Law

28 Sec. 1271.004. INDIVIDUAL HEALTH CARE PLAN. (a) In this
29 section, "individual health care plan" means a health care plan:

30 (1) that provides health care services for individuals
31 and their dependents;

32 (2) under which an enrollee:

33 (A) pays the premium; and

34 (B) is not covered under the contract in
35 accordance with a continuation of services or continuation of
36 benefits requirement applicable under federal or state law; and

37 (3) in which the evidence of coverage meets the
38 requirements of the definition of "basic health care services"
39 provided by Section 843.002.

40 (b) A health maintenance organization may provide an
41 individual health care plan in accordance with this section and
42 Section 1271.307.

1 (c) A health maintenance organization may limit enrollment
2 in an individual health care plan to individuals who reside or work
3 within the service area for the plan's network.

4 (d) The commissioner may adopt rules necessary to implement
5 this section and to meet the minimum requirements of federal law,
6 including regulations. (V.T.I.C. Art. 20A.09, Sec. (1) (part), as
7 added Acts 75th Leg., R.S., Ch. 837.)

8 Source Law

9 (1) Individual Health Care Plan. A health
10 maintenance organization may provide an individual
11 health care plan as required by this subsection.

12 (A) For purposes of this subsection, an
13 "individual health care plan" means:

14 (1) a health care plan providing
15 health care services for individuals and their
16 dependents;

17 (2) a health care plan in which an
18 enrollee pays the premium and is not being covered
19 under the contract pursuant to continuation of
20 services and benefits provisions applicable under
21 federal or state law; and

22 (3) a plan in which the evidence of
23 coverage meets the requirements of Section 2(a) of
24 this Act.

25 (B) A health maintenance organization may
26 limit its enrollees to those who live, reside, or work
27 within the service area for such network plan.

28
29 (D) The commissioner may adopt rules
30 necessary to implement this subsection and to meet the
31 minimum requirements of federal law and regulations.

32 Revisor's Note

33 (1) Section (1)(A)(3), V.T.I.C. Article 20A.09,
34 as added by Chapter 837, Acts of the 75th Legislature,
35 Regular Session, 1997, refers to "a plan in which the
36 evidence of coverage meets the requirements of Section
37 2(a) of this Act," meaning Section 2(a) of the Texas
38 Health Maintenance Organization Act (Section (a),
39 V.T.I.C. Article 20A.02). At the time of revision in
40 1999, Section 2(a), revised as Section 843.002(1) of
41 this code, defined the term "adverse determination."
42 However, at the time Chapter 837 was enacted, Section
43 2(a) defined the term "basic health care services." In
44 context, it is clear that the legislature intended to
45 refer to the definition of "basic health care

1 services." The revised law accordingly references
2 that definition.

3 (2) Section (1)(B), V.T.I.C. Article 20A.09, as
4 added by Chapter 837, Acts of the 75th Legislature,
5 Regular Session, 1997, refers to enrollees who "live,
6 reside, or work within the service area." Throughout
7 this chapter, the revised law omits "live" because in
8 this context it is included within the meaning of
9 "reside."

10 Revised Law

11 Sec. 1271.005. APPLICABILITY OF OTHER LAW. (a) Chapters
12 1368 and 1652 apply to a health maintenance organization other than
13 a health maintenance organization that offers only a single health
14 care service plan.

15 (b) Subchapter B, Chapter 1355, applies to a health
16 maintenance organization providing benefits for mental health
17 treatment in a residential treatment center for children and
18 adolescents or crisis stabilization unit to the extent that:

19 (1) Subchapter B, Chapter 1355, does not conflict with
20 this chapter, Chapter 843, or Subchapter A, Chapter 1452; and

21 (2) the residential treatment center for children and
22 adolescents or crisis stabilization unit is located within the
23 service area of the health maintenance organization and is subject
24 to inspection and review as required by this chapter, Chapter 843,
25 or Subchapter A, Chapter 1452, or rules adopted under this chapter,
26 Chapter 843, or Subchapter A, Chapter 1452.

27 (c) A health maintenance organization shall comply with
28 Subchapter B, Chapter 542, with respect to prompt payment to an
29 enrollee.

30 (d) Notwithstanding any other law, Subchapter C, Chapter
31 1355, applies to a group contract issued by a health maintenance
32 organization.

33 (e) Notwithstanding any other law, Section 1201.062 applies
34 to an evidence of coverage issued by a health maintenance

1 organization. (V.T.I.C. Art. 3.70-1, Sec. (F)(5) (part);
2 Art. 3.70-2, Secs. (F) (part), (L) (part), as amended Acts 77th
3 Leg., R.S., Chs. 396 and 1027; Art. 20A.09, Secs. (n), (p), (q), as
4 amended Acts 75th Leg., R.S., Ch. 905; (e), (f), (h), (i), as
5 amended Acts 75th Leg., R.S., Ch. 1026; Art. 20A.09Z.)

6 Source Law

7 [Art. 3.70-1]

8 (5) [The Board shall adopt rules and
9 regulations establishing minimum standards for
10 benefits for long-term care coverage under . . .]
11 under policies and evidences of coverages delivered or
12 issued for delivery in this state by health
13 maintenance organizations under the Texas Health
14 Maintenance Organization Act (Chapter 20A, Vernon's
15 Texas Insurance Code).

16 [Art. 3.70-2]

17 (F) A . . . group policy issued by a company
18 subject to . . . Chapter 20A, Texas Insurance Code,
19 that provides coverage . . . [if such coverage is
20 offered by or negotiated with such] . . . health
21 maintenance organization;

22 (L) [as amended Acts 77th Leg., R.S., Ch. 396]
23 An . . . evidence of coverage issued by a health
24 maintenance organization subject to the Texas Health
25 Maintenance Organization Act (Chapter 20A, Vernon's
26 Texas Insurance Code),

27 (L) [as amended Acts 77th Leg., R.S., Ch. 1027]
28 An . . . evidence of coverage issued by a health
29 maintenance organization subject to the Texas Health
30 Maintenance Organization Act (Chapter 20A, Vernon's
31 Texas Insurance Code),

32 [Art. 20A.09, as amended Acts 75th Leg., R.S., Ch.
33 905]

34 (n) Articles 3.51-9 and 3.74, Insurance Code,
35 and Section 1(F)(5), Chapter 397, Acts of the 54th
36 Legislature, Regular Session, 1955 (Article
37 3.70-1(F)(5), Vernon's Texas Insurance Code), apply to
38 health maintenance organizations other than those
39 health maintenance organizations offering only a
40 single health care service plan.

41 (p) Article 3.72 of the Insurance Code applies
42 to health maintenance organizations to the extent that
43 such article is not in conflict with this Act and to
44 the extent that the residential treatment center or
45 crisis stabilization unit is located within the
46 service area of the health maintenance organization
47 and subject to such inspection and review as required
48 by this Act or the rules hereunder.

49 (q) Article 21.55, Insurance Code, applies to
50 out-of-area or emergency claims for which benefits are
51 not assigned or payment is not made directly to the
52 physician or provider.

53 [Art. 20A.09, as amended Acts 75th Leg., R.S., Ch.
54 1026]

55 (e) Article 3.74 of the Texas Insurance Code
56 applies to health maintenance organizations other than

1 those health maintenance organizations offering only a
2 single health care service plan.

3 (f) Article 3.51-9 of the Texas Insurance Code
4 applies to health maintenance organizations other than
5 those health maintenance organizations offering only a
6 single health care service plan.

7 (h) Article 3.70-1(F)(5) of the Insurance Code
8 applies to health maintenance organizations other than
9 those health maintenance organizations offering only a
10 single health care service plan.

11 (i) Article 3.72 of the Insurance Code applies
12 to health maintenance organizations to the extent that
13 such article is not in conflict with this Act and to
14 the extent that the residential treatment center or
15 crisis stabilization unit is located within the
16 service area of the health maintenance organization
17 and subject to such inspection and review as required
18 by this Act or the rules hereunder.

19 Art. 20A.09Z. A health maintenance organization
20 shall comply with Article 21.55 of the Insurance Code
21 with respect to prompt payment to enrollees.

22 Revisor's Note

23 (1) Section (q), V.T.I.C. Article 20A.09, as
24 amended by Chapter 905, Acts of the 75th Legislature,
25 Regular Session, 1997, states that Article 21.55,
26 Insurance Code, applies to certain claims for which
27 benefits are not assigned and for which payment is not
28 made directly to the physician or provider. V.T.I.C.
29 Article 20A.09Z (formerly Section (j), V.T.I.C.
30 Article 20A.09, as amended by Section 7, Chapter 1026,
31 Acts of the 75th Legislature, Regular Session, 1997),
32 states that Article 21.55, Insurance Code, applies
33 with respect to prompt payment to enrollees.

34 The amendment to Section (q) made by Chapter 905
35 only corrected a deficient citation without changing
36 the substantive language of the section. Section 7,
37 Chapter 1026, amended the substantive language of the
38 same provision by substituting a requirement that
39 Article 21.55, Insurance Code, apply with respect to
40 prompt payment to enrollees.

41 Section 312.014, Government Code, provides that
42 in this circumstance the amendment to the statute that
43 substantively changed the language of the statute

1 prevails over the amendment that only reenacted
2 existing language without substantive change. The
3 revised law accordingly gives effect to the Chapter
4 1026 substantive amendment.

5 (2) Section (p), V.T.I.C. Article 20A.09, as
6 amended by Chapter 905, Acts of the 75th Legislature,
7 Regular Session, 1997, and Section (i), V.T.I.C.
8 Article 20A.09, as amended by Chapter 1026, Acts of the
9 75th Legislature, Regular Session, 1997, provide that
10 V.T.I.C. Article 3.72 (revised as Subchapter B,
11 Chapter 1355, of this code), which requires a group
12 policy of accident and health insurance to provide
13 coverage for mental health treatment in a residential
14 treatment center or crisis stabilization unit, applies
15 to a health maintenance organization to the extent
16 that it does not conflict with the Texas Health
17 Maintenance Organization Act (V.T.I.C. Chapter 20A)
18 and to the extent that the residential treatment
19 center or crisis stabilization unit is subject to
20 inspection and review as required by that act. A
21 majority of V.T.I.C. Chapter 20A was revised in 2001 as
22 Chapter 843 of this code. Additional portions of
23 Chapter 20A are revised in this chapter. The remaining
24 portions of Chapter 20A are revised in this code in
25 Chapters 222 and 258, which impose premium and
26 maintenance taxes on health maintenance
27 organizations; Chapter 1272, which deals with
28 delegated networks; Chapter 1367, in part, which
29 requires health maintenance organizations to provide
30 coverage for certain childhood immunizations; and
31 Chapter 1452, in part, which deals with credentialing
32 of physicians and providers by health maintenance
33 organizations. Because the issues of taxes, delegated
34 networks, and childhood immunization coverage are

1 irrelevant to whether a requirement to provide
2 coverage for certain mental health treatment applies
3 to a health maintenance organization, and because the
4 chapters dealing with those issues do not impose
5 requirements relating to the inspection and review of
6 treatment facilities, the revised law refers only to
7 this chapter, Chapter 843, and Subchapter A, Chapter
8 1452, of this code.

9 Revised Law

10 Sec. 1271.006. BENEFITS TO DEPENDENT CHILD AND
11 GRANDCHILD. (a) If children are eligible for coverage under the
12 terms of an evidence of coverage, any limiting age applicable to an
13 unmarried child of an enrollee, including an unmarried grandchild
14 of an enrollee, is 25 years of age. The limiting age applicable to a
15 child must be stated in the evidence of coverage.

16 (b) A health maintenance organization may provide benefits
17 under a health care plan to an enrollee's dependent grandchild who
18 is living with and in the household of the enrollee. (V.T.I.C. Art.
19 20A.09H, Sec. (a), as redesignated and amended Acts 77th Leg.,
20 R.S., Ch. 396; Art. 20A.09H, as redesignated and amended Acts 77th
21 Leg., R.S., Ch. 1027.)

22 Source Law

23 Art. 20A.09H. [as redesignated and amended Acts
24 77th Leg., R.S., Ch. 396] (a) A health maintenance
25 organization may provide benefits under a health care
26 plan to a dependent grandchild of an enrollee when the
27 dependent grandchild is less than 21 years old and
28 living with and in the household of the enrollee.

29 Art. 20A.09H. [as redesignated and amended Acts
30 77th Leg., R.S., Ch. 1027] (a) If children are
31 eligible for coverage under the terms of an evidence of
32 coverage, any limiting age applicable to an unmarried
33 child of an enrollee, including an unmarried
34 grandchild of an enrollee, is 25 years of age. The
35 limiting age applicable to a child must be stated in
36 the evidence of coverage.

37 (b) A health maintenance organization may
38 provide benefits under a health care plan to a
39 dependent grandchild of an enrollee who is living with
40 and in the household of the enrollee.

41 Revisor's Note

42 V.T.I.C. Article 20A.09H was amended by Chapters

1 396 and 1027, Acts of the 77th Legislature, Regular
2 Session, 2001.

3 Chapter 396 amended the article to provide that a
4 grandchild of an enrollee is a dependent, regardless
5 of whether the enrollee treats the grandchild as a
6 dependent for federal income tax purposes. Chapter
7 1027 amended the article to increase the age of an
8 eligible grandchild from 21 to 25 years, and the
9 revised law reflects that change. Chapter 1027 also,
10 however, amended Section (L), V.T.I.C. Article 3.70-2,
11 which applies to an evidence of coverage issued by a
12 health maintenance organization and which must be read
13 in conjunction with Article 20A.09H. Section (L), as
14 amended by Chapter 1027, provides that a grandchild
15 may receive coverage only if the grandchild is a
16 dependent of the enrollee for federal income tax
17 purposes at the time application for coverage is made.

18 It is impossible to give effect to both
19 amendments made by Chapters 396 and 1027 regarding the
20 issue of whether a grandchild is required to be a
21 dependent for federal income tax purposes. Under
22 basic rules of statutory construction, codified in
23 Sections 311.025 and 312.014, Government Code, which
24 apply to this revision, if it is impossible to read two
25 acts of the same legislative session together so that
26 effect may be given to both, the latest enactment is
27 read as an implied repeal of the earlier act to the
28 extent of the conflict. The last legislative action on
29 Chapter 396 occurred on May 15, 2001. The last
30 legislative action on Chapter 1027 occurred on May 22,
31 2001. Therefore, the amendment made by Chapter 1027
32 requiring a grandchild to be a dependent for federal
33 income tax purposes impliedly repealed the amendment
34 adopted under Chapter 396 providing that a grandchild

1 is a dependent, regardless of whether the grandchild
2 is treated as a dependent for federal income tax
3 purposes. The revised law accordingly omits the
4 amendment adopted under Chapter 396. The omitted law
5 reads:

6 (b) For purposes of this section, a
7 grandchild of an enrollee is a dependent,
8 regardless of whether the enrollee treats
9 the grandchild as a dependent for federal
10 income tax purposes.

11 Revised Law

12 Sec. 1271.007. RELIGIOUS CONVICTIONS. (a) This chapter,
13 Chapters 843, 1272, and 1367, and Subchapter A, Chapter 1452, do not
14 require a health maintenance organization, physician, or provider
15 to recommend, offer advice concerning, pay for, provide, assist in,
16 perform, arrange, or participate in providing or performing any
17 health care service that violates the religious convictions of the
18 health maintenance organization, physician, or provider.

19 (b) A health maintenance organization that limits or denies
20 health care services under this section shall state the limitations
21 in the evidence of coverage as required by Section 1271.052.
22 (V.T.I.C. Art. 20A.09, Sec. (m), as added Acts 75th Leg., R.S., Ch.
23 1026.)

24 Source Law

25 (m) Nothing in this Act shall require a health
26 maintenance organization, physician, or provider to
27 recommend, offer advice concerning, pay for, provide,
28 assist in, perform, arrange, or participate in
29 providing or performing any health care service that
30 violates its religious convictions. A health
31 maintenance organization that limits or denies health
32 care services under this subsection shall set forth
33 such limitations in the evidence of coverage as
34 required by Section 9(a)(3) of this Act.

35 Revisor's Note

36 Section (m), V.T.I.C. Article 20A.09, as added by
37 Chapter 1026, Acts of the 75th Legislature, Regular
38 Session, 1997, provides that the Texas Health
39 Maintenance Organization Act (V.T.I.C. Chapter 20A)
40 does not require a health maintenance organization,

1 physician, or provider to engage in certain activities
2 that violate the religious convictions of the
3 organization, physician, or provider. A majority of
4 V.T.I.C. Chapter 20A was revised in 2001 as Chapter 843
5 of this code. Additional portions of Chapter 20A are
6 revised in this chapter. The remaining portions of
7 Chapter 20A are revised in this code in Chapters 222
8 and 258, which impose premium and maintenance taxes on
9 health maintenance organizations; Chapter 1272, which
10 deals with delegated networks; Chapter 1367, in part,
11 which requires health maintenance organizations to
12 provide coverage for certain childhood immunizations;
13 and Chapter 1452, in part, which deals with
14 credentialing of physicians and providers by health
15 maintenance organizations. Because the issue of taxes
16 is irrelevant to whether an activity violates the
17 religious convictions of a health maintenance
18 organization, physician, or provider, the revised law
19 does not refer to Chapter 222 or 258 of this code.

20 [Sections 1271.008-1271.050 reserved for expansion]

21 SUBCHAPTER B. CONTENTS OF EVIDENCE OF COVERAGE

22 Revised Law

23 Sec. 1271.051. EVIDENCE OF COVERAGE: CONTRACT AND
24 CERTIFICATE REQUIREMENTS. (a) An evidence of coverage that is a
25 contract must contain a clear and complete statement of the
26 information required by Sections 1271.052, 1271.053, and 1271.054.

27 (b) An evidence of coverage that is a certificate must
28 contain a reasonably complete facsimile of the information required
29 by Sections 1271.052, 1271.053, and 1271.054. (V.T.I.C.
30 Art. 20A.09, Secs. (e) (part), as amended Acts 75th Leg., R.S., Ch.
31 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

32 Source Law

33 (e) [as amended Acts 75th Leg., R.S., Ch. 905]
34 Each evidence or coverage must contain a clear and
35 complete statement, if a contract, or a reasonably

1 complete facsimile, if a certificate, of:
2 . . .

3 (a) [as amended Acts 75th Leg., R.S., Ch. 1026]
4 . . .

5 (3) An evidence of coverage shall contain:
6 . . .

7 (B) a clear and complete statement,
8 if a contract, or a reasonably complete facsimile, if a
9 certificate, of:
10 . . .

11 Revised Law

12 Sec. 1271.052. INFORMATION ABOUT BENEFITS AND
13 LIMITATIONS. An evidence of coverage must state:

14 (1) the health care services, limited health care
15 services, or single health care service to which the enrollee is
16 entitled under the health care plan, limited health care service
17 plan, or single health care service plan;

18 (2) the issuance of other benefits, if any, to which
19 the enrollee is entitled under the health care plan, limited health
20 care service plan, or single health care service plan; and

21 (3) any limitation on the services, kinds of services,
22 benefits, or kinds of benefits to be provided, including any
23 deductible or copayment feature. (V.T.I.C. Art. 20A.09, Secs. (e)
24 (part), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as
25 amended Acts 75th Leg., R.S., Ch. 1026.)

26 Source Law

27 (e) [as amended Acts 75th Leg., R.S., Ch. 905]
28 [Each evidence or coverage must contain a clear and
29 complete statement, if a contract, or a reasonably
30 complete facsimile, if a certificate, of:]

31 (1) the medical, health care services,
32 limited health care services, or single health care
33 service and the issuance of other benefits, if any, to
34 which the enrollee is entitled under the health care
35 plan, limited health care service plan, or single
36 health care service plan;

37 (2) any limitation on the services, kinds
38 of services, benefits, or kinds of benefits to be
39 provided, including any deductible or co-payment
40 feature;
41 . . .

42 (a) [as amended Acts 75th Leg., R.S., Ch. 1026]
43 . . .

44 [(3) An evidence of coverage shall
45 contain:
46 . . .

47 (B) a clear and complete statement,
48 if a contract, or a reasonably complete facsimile, if a
49 certificate, of:]

1 (i) the medical, health care
2 services, limited health care services, or single
3 health care service and the issuance of other
4 benefits, if any, to which the enrollee is entitled
5 under the health care plan, limited health care
6 service plan, or single health care service plan;

7 (ii) any limitation on the
8 services, kinds of services, benefits, or kinds of
9 benefits to be provided, including any deductible or
10 co-payment feature;

11 . . .

12 Revisor's Note

13 Section (e)(1), V.T.I.C. Article 20A.09, as
14 amended by Chapter 905, Acts of the 75th Legislature,
15 Regular Session, 1997, and Section (a)(3)(B)(i),
16 V.T.I.C. Article 20A.09, as amended by Chapter 1026,
17 Acts of the 75th Legislature, Regular Session, 1997,
18 refer to "medical [and] health care services."
19 Throughout this chapter, the revised law omits
20 references to "medical" or "medical care" in this
21 context as unnecessary because Section 843.002 of this
22 code includes medical care within the definition of
23 "health care services."

24 Revised Law

25 Sec. 1271.053. INFORMATION ABOUT OBTAINING SERVICES. An
26 evidence of coverage must indicate where and in what manner
27 information is available about how to obtain services. (V.T.I.C.
28 Art. 20A.09, Secs. (e) (part), as amended Acts 75th Leg., R.S., Ch.
29 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

30 Source Law

31 (e) [as amended Acts 75th Leg., R.S., Ch. 905]
32 [Each evidence of coverage must contain a clear and
33 complete statement, if a contract, or a reasonably
34 complete facsimile, if a certificate, of:]

35 . . .
36 (3) where and in what manner information
37 is available as to how services may be obtained; and
38 . . .

39 (a) [as amended Acts 75th Leg., R.S., Ch. 1026]
40 . . .
41 [(3) An evidence of coverage shall
42 contain:

43 . . .
44 (B) a clear and complete statement,
45 if a contract, or a reasonably complete facsimile, if a
46 certificate, of:]
47 . . .

1 (iii) where and in what manner
2 information is available as to how services may be
3 obtained; and

4 . . .

5 Revised Law

6 Sec. 1271.054. INFORMATION ABOUT COMPLAINTS AND
7 APPEALS. (a) An evidence of coverage must contain a clear and
8 understandable description of the health maintenance
9 organization's methods for resolving enrollee complaints,
10 including:

11 (1) the enrollee's right to appeal denial of an adverse
12 determination to an independent review organization; and

13 (2) the procedures for appealing to an independent
14 review organization.

15 (b) A health maintenance organization may indicate a
16 subsequent change to the methods for resolving enrollee complaints
17 in a separate document issued to the enrollee. (V.T.I.C.
18 Art. 20A.09, Secs. (e) (part), as amended Acts 75th Leg., R.S., Ch.
19 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

20 Source Law

21 (e) [as amended Acts 75th Leg., R.S., Ch. 905]
22 [Each evidence or coverage must contain a clear and
23 complete statement, if a contract, or a reasonably
24 complete facsimile, if a certificate, of:]

25 . . .
26 (4) a clear and understandable description
27 of the health maintenance organization's methods for
28 resolving enrollee complaints, including the
29 enrollee's right to appeal denials of an adverse
30 determination, as that term is defined by Section 12A
31 of this Act, to an independent review organization and
32 the procedures for making an appeal to an independent
33 review organization. Any subsequent changes may be
34 evidenced in a separate document issued to the
35 enrollee.

36 (a) [as amended Acts 75th Leg., R.S., Ch. 1026]
37 . . .
38 [(3) An evidence of coverage shall
39 contain:

40 . . .
41 (B) a clear and complete statement,
42 if a contract, or a reasonably complete facsimile, if a
43 certificate, of:]

44 . . .
45 (iv) a clear and understandable
46 description of the health maintenance organization's
47 methods for resolving enrollee complaints, including
48 the enrollee's right to appeal denials of an adverse
49 determination, as that term is defined by Section 12A
50 of this Act, to an independent review organization and

1 the procedures for making an appeal to an independent
2 review organization. Any subsequent changes may be
3 evidenced in a separate document issued to the
4 enrollee;

5 . . .

6 Revisor's Note

7 Section (e)(4), V.T.I.C. Article 20A.09, as
8 amended by Chapter 905, Acts of the 75th Legislature,
9 Regular Session, 1997, and Section (a)(3), V.T.I.C.
10 Article 20A.09, as amended by Chapter 1026, Acts of the
11 75th Legislature, Regular Session, 1997, refer to an
12 adverse determination, "as that term is defined by
13 Section 12A of this Act." The revised law omits the
14 reference to the definition in Section 12A, Texas
15 Health Maintenance Organization Act, because the
16 relevant part of that section is revised in Section
17 843.002 of this code, and Section 1271.001 states that
18 in this chapter, terms defined by Section 843.002 have
19 the meanings assigned by that section.

20 Revised Law

21 Sec. 1271.055. OUT-OF-NETWORK SERVICES. (a) An evidence of
22 coverage must contain a provision regarding non-network physicians
23 and providers in accordance with the requirements of this section.

24 (b) If medically necessary covered services are not
25 available through network physicians or providers, the health
26 maintenance organization, on the request of a network physician or
27 provider and within a reasonable period, shall:

28 (1) allow referral to a non-network physician or
29 provider; and

30 (2) fully reimburse the non-network physician or
31 provider at the usual and customary rate or at an agreed rate.

32 (c) Before denying a request for a referral to a non-network
33 physician or provider, a health maintenance organization must
34 provide for a review conducted by a specialist of the same or
35 similar type of specialty as the physician or provider to whom the
36 referral is requested. (V.T.I.C. Art. 20A.09, Secs. (d), (f), as

1 amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended
2 Acts 75th Leg., R.S., Ch. 1026.)

3 Source Law

4 [Art. 20A.09, as amended Acts 75th Leg., R.S., Ch.
5 905]

6 (d) Each evidence of coverage must contain
7 provisions regarding the requirements adopted under
8 Subsections (e)-(i) of this section.

9 (f) If medically necessary covered services are
10 not available through network physicians or providers,
11 the health maintenance organization, on the request of
12 a network physician or provider, within a reasonable
13 period, shall allow referral to a non-network
14 physician or provider and shall fully reimburse the
15 non-network physician or provider at the usual and
16 customary or an agreed rate. The evidence of coverage
17 must provide for a review by a specialist of the same
18 specialty or a similar specialty as the type of
19 physician or provider to whom a referral is requested
20 before the health maintenance organization may deny a
21 referral.

22 [Art. 20A.09, Sec. (a), as amended Acts 75th Leg.,
23 R.S., Ch. 1026]

24 [(3) An evidence of coverage shall
25 contain:]

26 . . .
27 (C) a provision that, if medically
28 necessary covered services are not available through
29 network physicians or providers, the health
30 maintenance organization must, on the request of a
31 network physician or provider, within a reasonable
32 time period allow referral to a non-network physician
33 or provider and shall fully reimburse the non-network
34 physician or provider at the usual and customary or an
35 agreed rate; each contract must further provide for a
36 review by a specialist of the same, or a similar,
37 specialty as the physician or provider to whom a
38 referral is requested before the health maintenance
39 organization may deny a referral;
40 . . .

41 Revised Law

42 Sec. 1271.056. UNFAIR OR DECEPTIVE PROVISIONS AND
43 STATEMENTS PROHIBITED. An evidence of coverage may not contain a
44 provision or statement that:

45 (1) is unjust, unfair, inequitable, misleading, or
46 deceptive;

47 (2) encourages misrepresentation; or

48 (3) is untrue, misleading, or deceptive within the
49 meaning of Section 843.204. (V.T.I.C. Art. 20A.09, Secs. (c), as
50 amended Acts 75th Leg., R.S., Ch. 905; (a)(3) (part), as amended
51 Acts 75th Leg., R.S., Ch. 1026.)

1 (b) No evidence of coverage, or amendment
2 thereto, shall be issued or delivered to any person in
3 this state until a copy of the form of evidence of
4 coverage, or amendment thereto, has been filed with
5 and approved by the commissioner.

6 (j) Any form of the evidence of coverage or
7 group contract to be used in this state, and any
8 amendments thereto, are subject to the filing and
9 approval requirements of Subsection (l) of this
10 section, unless it is subject to the jurisdiction of
11 the commissioner under the laws governing health
12 insurance or group hospital service corporations, in
13 which event the filing and approval provisions of such
14 law shall apply. To the extent, however, that such
15 provisions do not apply to the requirements of
16 Subsections (c)-(i) of this section, the requirements
17 of those subsections apply.

18 [Art. 20A.09, Sec. (a), as amended Acts 75th Leg.,
19 R.S., Ch. 1026]

20 (2) No evidence of coverage, or amendment
21 thereto, shall be issued or delivered to any person in
22 this state until a copy of the form of evidence of
23 coverage, or amendment thereto, has been filed with
24 and approved by the commissioner.

25 (5) Any form of the evidence of coverage or
26 group contract to be used in this state, and any
27 amendments thereto, are subject to the filing and
28 approval requirements of Subsection (c) of this
29 section, unless it is subject to the jurisdiction of
30 the commissioner under the laws governing health
31 insurance or group hospital service corporations, in
32 which event the filing and approval provisions of such
33 law shall apply. To the extent, however, that such
34 provisions do not apply to the requirements of
35 Subdivision (3) of this subsection, the requirements
36 of Subdivision (3) shall be applicable.

37 Revised Law

38 Sec. 1271.102. PROCEDURES FOR APPROVAL OF FORM OF EVIDENCE
39 OF COVERAGE OR GROUP CONTRACT; WITHDRAWAL OF APPROVAL. (a) The
40 commissioner shall, within a reasonable period, approve the form of
41 an evidence of coverage or group contract or an amendment to one of
42 those forms if the form meets the requirements of this chapter.

43 (b) If the commissioner does not disapprove a form before
44 the 31st day after the date the form is filed, the form is
45 considered approved. The commissioner may, by written notice,
46 extend the period for approval or disapproval as necessary for
47 proper consideration of the filing for not more than an additional
48 30 days.

49 (c) If the commissioner disapproves a form, the
50 commissioner shall notify the person who filed the form of the

1 reason for the disapproval.

2 (d) A hearing on the disapproval of a form shall be granted
3 not later than the 30th day after the date the person filing the
4 form makes a written request for a hearing. (V.T.I.C. Art. 20A.09,
5 Secs. (1) (part), as amended Acts 75th Leg., R.S., Ch. 905; (c)
6 (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

7 Source Law

8 (1) [as amended Acts 75th Leg., R.S., Ch. 905]
9 The commissioner shall, within a reasonable period,
10 approve any form of the evidence of coverage or group
11 contract, or amendment thereto, if the requirements of
12 this section are met. . . . If the commissioner
13 disapproves such form, the commissioner shall notify
14 the filer. In the notice, the commissioner shall
15 specify the reason for the disapproval. A hearing
16 shall be granted within 30 days after a request in
17 writing by the person filing. If the commissioner does
18 not disapprove any form within 30 days after the filing
19 of such form it shall be considered approved; provided
20 that the commissioner may by written notice extend the
21 period for approval or disapproval of any filing for
22 such further time, not exceeding an additional 30
23 days, as necessary for proper consideration of the
24 filing.

25 (c) [as amended Acts 75th Leg., R.S., Ch. 1026]
26 The commissioner shall, within a reasonable period,
27 approve any form of the evidence of coverage or group
28 contract, or amendment thereto, if the requirements of
29 this section are met. . . . If the commissioner
30 disapproves such form, the commissioner shall notify
31 the filer. In the notice, the commissioner shall
32 specify the reason for the disapproval. A hearing
33 shall be granted within 30 days after a request in
34 writing by the person filing. If the commissioner does
35 not disapprove any form within 30 days after the filing
36 of such form it shall be considered approved; provided
37 that the commissioner may by written notice extend the
38 period for approval or disapproval of any filing for
39 such further time, not exceeding an additional 30
40 days, as necessary for proper consideration of the
41 filing.

42 Revised Law

43 Sec. 1271.103. WITHDRAWAL OF APPROVAL OF FORM. (a) After
44 notice and opportunity for hearing, the commissioner may withdraw
45 approval of the form of an evidence of coverage or group contract or
46 an amendment to one of those forms if the commissioner determines
47 that the form violates this chapter, Chapter 843, 1272, or 1367, or
48 Subchapter A, Chapter 1452, or a rule adopted by the commissioner.

49 (b) If the commissioner withdraws approval of a form under
50 this section, the form may not be issued until it is approved.

1 (V.T.I.C. Art. 20A.09, Secs. (1) (part), as amended Acts 75th Leg.,
2 R.S., Ch. 905; (c) (part), as amended Acts 75th Leg., R.S., Ch.
3 1026.)

4 Source Law

5 (1) [as amended Acts 75th Leg., R.S., Ch.
6 905] . . . After notice and hearing, the commissioner
7 may withdraw previous approval of any form, if the
8 commissioner determines that it violates or does not
9 comply with this Act or a rule adopted by the
10 commissioner. It shall be unlawful to issue such form
11 until approved. . . .

12 (c) [as amended Acts 75th Leg., R.S., Ch.
13 1026] . . . After notice and opportunity for hearing,
14 the commissioner may withdraw previous approval of any
15 form, if the commissioner determines that it violates
16 or does not comply with this Act or a rule adopted by
17 the commissioner. It shall be unlawful to issue such
18 form until approved. . . .

19 Revisor's Note

20 (1) In 1997, Section (c), V.T.I.C. Article
21 20A.09, was amended by Chapters 905 and 1026, Acts of
22 the 75th Legislature, Regular Session. Chapter 905
23 relettered Section (c) as Section (1) and corrected a
24 reference to the State Board of Insurance without
25 changing the substantive language of the section.
26 Chapter 1026 also corrected the State Board of
27 Insurance reference and, in addition, amended the
28 substantive language of the section by requiring an
29 "opportunity for hearing" instead of a "hearing"
30 before the commissioner of insurance may withdraw
31 certain approvals. Section 312.014, Government Code,
32 provides that in this circumstance the amendment to
33 the statute that substantively changed the language of
34 the statute prevails over the amendment that only
35 reenacted existing language without substantive
36 change. The revised law accordingly gives effect to
37 the Chapter 1026 substantive amendment.

38 (2) Section (1), V.T.I.C. Article 20A.09, as
39 amended by Chapter 905, Acts of the 75th Legislature,
40 Regular Session, 1997, and Section (c), V.T.I.C.

1 Article 20A.09, as amended by Chapter 1026, Acts of the
2 75th Legislature, Regular Session, 1997, refer to a
3 form that "violates or does not comply with this Act."
4 The revised law omits the references to "does not
5 comply with" as unnecessary because "does not comply
6 with" is included within the meaning of "violates."

7 (3) Section (1), V.T.I.C. Article 20A.09, as
8 amended by Chapter 905, Acts of the 75th Legislature,
9 Regular Session, 1997, and Section (c), V.T.I.C.
10 Article 20A.09, as amended by Chapter 1026, Acts of the
11 75th Legislature, Regular Session, 1997, provide that
12 the commissioner of insurance may withdraw the
13 commissioner's approval of the form of certain
14 documents if the commissioner determines that the form
15 violates the Texas Health Maintenance Organization Act
16 (V.T.I.C. Chapter 20A). A majority of V.T.I.C.
17 Chapter 20A was revised in 2001 as Chapter 843 of this
18 code. Additional portions of Chapter 20A are revised
19 in this chapter. The remaining portions of Chapter 20A
20 are revised in this code in Chapters 222 and 258, which
21 impose premium and maintenance taxes on health
22 maintenance organizations; Chapter 1272, which deals
23 with delegated networks; Chapter 1367, in part, which
24 requires health maintenance organizations to provide
25 coverage for certain childhood immunizations; and
26 Chapter 1452, in part, which deals with credentialing
27 of physicians and providers by health maintenance
28 organizations. Because the issue of taxes is
29 irrelevant to the commissioner's determination
30 regarding the form of a document, the revised law does
31 not refer to Chapter 222 or 258 of this code.

32 Revised Law

33 Sec. 1271.104. INFORMATION REQUIRED BY COMMISSIONER. The
34 commissioner may require the submission of any relevant information

1 the commissioner considers necessary in determining whether to
2 approve or disapprove a filing under this subchapter. (V.T.I.C.
3 Art. 20A.09, Secs. (m), as amended Acts 75th Leg., R.S., Ch. 905;
4 (d), as amended Acts 75th Leg., R.S., Ch. 1026.)

5 Source Law

6 (m) [as amended Acts 75th Leg., R.S., Ch. 905]
7 The commissioner may require the submission of
8 whatever relevant information he or she deems
9 necessary in determining whether to approve or
10 disapprove a filing made pursuant to this section.

11 (d) [as amended Acts 75th Leg., R.S., Ch. 1026]
12 The commissioner may require the submission of
13 whatever relevant information he or she deems
14 necessary in determining whether to approve or
15 disapprove a filing made pursuant to this section.

16 [Sections 1271.105-1271.150 reserved for expansion]

17 SUBCHAPTER D. CERTAIN BENEFITS REQUIRED

18 Revised Law

19 Sec. 1271.151. PROVISION OF BASIC HEALTH CARE SERVICES. A
20 health maintenance organization that offers a basic health care
21 plan shall provide or arrange for basic health care services to its
22 enrollees as needed and without limitation as to time and cost other
23 than any limitation prescribed by rule of the commissioner.
24 (V.T.I.C. Art. 20A.09, Sec. (l), as added Acts 75th Leg., R.S., Ch.
25 1026.)

26 Source Law

27 (l) A health maintenance organization that
28 offers a basic health care plan shall provide or
29 arrange for the provision of basic health care
30 services to its enrollees as needed and without
31 limitations as to time and cost other than limitations
32 prescribed by rule of the commissioner.

33 Revised Law

34 Sec. 1271.152. STANDARDS FOR BASIC HEALTH CARE
35 SERVICES. The commissioner may adopt minimum standards relating
36 to basic health care services. (V.T.I.C. Art. 20A.09, Sec. (n), as
37 added Acts 75th Leg., R.S., Ch. 1026.)

38 Source Law

39 (n) The commissioner may adopt minimum
40 standards relating to basic health care services.

1 Revised Law

2 Sec. 1271.153. PERIODIC HEALTH EVALUATIONS. (a) The
3 basic health care services provided under an evidence of coverage
4 must include periodic health evaluations for each adult enrollee.

5 (b) The services provided under this section must include a
6 health risk assessment at least once every three years and, for a
7 female enrollee, an annual well-woman examination provided in
8 accordance with Subchapter F, Chapter 1451.

9 (c) This section does not apply to an evidence of coverage
10 for a limited health care service plan or a single health care
11 service plan. (V.T.I.C. Art. 20A.09B.)

12 Source Law

13 Art. 20A.09B. (a) The basic health care services
14 provided under an evidence of coverage must include
15 periodic health evaluations for each adult enrollee.

16 (b) The services provided under this section
17 must include a health risk assessment at least once
18 every three years and, for a female enrollee, an annual
19 well-woman examination provided in accordance with
20 Article 21.53D of this code, as added by Chapter 912,
21 Acts of the 75th Legislature, Regular Session, 1997.

22 (c) This section does not apply to an evidence
23 of coverage for a limited health care service plan or a
24 single health care service plan.

25 Revised Law

26 Sec. 1271.154. WELL-CHILD CARE FROM BIRTH. (a) In this
27 section, "well-child care from birth" has the meaning used under
28 Section 1302, Public Health Service Act (42 U.S.C. Section 300e-1),
29 and its subsequent amendments. The term includes newborn screening
30 required by the Texas Department of Health.

31 (b) A health maintenance organization shall ensure that
32 each health care plan provided by the health maintenance
33 organization includes well-child care from birth that complies
34 with:

35 (1) federal requirements adopted under Chapter XI,
36 Public Health Service Act (42 U.S.C. Section 300e et seq.), and its
37 subsequent amendments; and

38 (2) the rules adopted by the Texas Department of
39 Health to implement those requirements. (V.T.I.C. Art. 20A.09E.)

1 (d) A health maintenance organization shall respond to
2 inquiries from a treating physician or provider in compliance with
3 this provision in the health care plan of the health maintenance
4 organization.

5 (e) A health care plan of a health maintenance organization
6 shall comply with this section regardless of whether the physician
7 or provider furnishing the emergency care has a contractual or
8 other arrangement with the health maintenance organization to
9 provide items or services to covered enrollees. (V.T.I.C. Art.
10 20A.09Y, as added Acts 77th Leg., R.S., Ch. 1419.)

11 Source Law

12 Art. 20A.09Y. A health maintenance organization
13 shall pay for emergency care services performed by
14 non-network physicians or providers at the negotiated
15 or usual and customary rate and that the health care
16 plan contains, without regard to whether the physician
17 or provider furnishing the services has a contractual
18 or other arrangement with the entity to provide items
19 or services to covered individuals, the following
20 provisions and procedures for coverage of emergency
21 care services:

22 (1) any medical screening examination or
23 other evaluation required by state or federal law that
24 is necessary to determine whether an emergency medical
25 condition exists will be provided to covered enrollees
26 in a hospital emergency facility or comparable
27 facility;

28 (2) necessary emergency care services will
29 be provided to covered enrollees, including the
30 treatment and stabilization of an emergency medical
31 condition; and

32 (3) services originated in a hospital
33 emergency facility or comparable facility following
34 treatment or stabilization of an emergency medical
35 condition will be provided to covered enrollees as
36 approved by the health maintenance organization,
37 provided that the health maintenance organization is
38 required to approve or deny coverage of
39 poststabilization care as requested by a treating
40 physician or provider within the time appropriate to
41 the circumstances relating to the delivery of the
42 services and the condition of the patient, but in no
43 case to exceed one hour from the time of the request;
44 the health maintenance organization must respond to
45 inquiries from the treating physician or provider in
46 compliance with this provision in the health
47 maintenance organization's plan.

48 Revised Law

49 Sec. 1271.156. BENEFITS FOR REHABILITATION SERVICES AND
50 THERAPIES. (a) If benefits are provided for rehabilitation
51 services and therapies under an evidence of coverage, the provision

1 of a rehabilitation service or therapy that, in the opinion of a
2 physician, is medically necessary may not be denied, limited, or
3 terminated if the service or therapy meets or exceeds treatment
4 goals for the enrollee.

5 (b) For an enrollee with a physical disability, treatment
6 goals may include maintenance of functioning or prevention of or
7 slowing of further deterioration. (V.T.I.C. Art. 20A.09, Sec.
8 (a)(4), as amended Acts 75th Leg., R.S., Ch. 1026.)

9 Source Law

10 (4) If an evidence of coverage provides
11 benefits for rehabilitation services and therapies,
12 the provision of those services and therapies that, in
13 the opinion of a physician, are medically necessary
14 may not be denied, limited, or terminated if they meet
15 or exceed treatment goals for the enrollee. For a
16 physically disabled person, treatment goals may
17 include maintenance of functioning or prevention of or
18 slowing of further deterioration.

19 [Sections 1271.157-1271.200 reserved for expansion]

20 SUBCHAPTER E. CHOICE OF PRIMARY CARE PHYSICIAN FOR
21 CERTAIN ENROLLEES

22 Revised Law

23 Sec. 1271.201. DESIGNATION OF SPECIALIST AS PRIMARY CARE
24 PHYSICIAN. (a) An evidence of coverage must provide that an
25 enrollee with a chronic, disabling, or life-threatening illness may
26 apply to the health maintenance organization's medical director to
27 use a nonprimary care physician specialist as the enrollee's
28 primary care physician.

29 (b) The application must:

30 (1) include information specified by the health
31 maintenance organization, including certification of the medical
32 need; and

33 (2) be signed by the enrollee and the nonprimary care
34 physician specialist interested in serving as the enrollee's
35 primary care physician.

36 (c) To be eligible to serve as the enrollee's primary care
37 physician, a physician specialist must:

38 (1) meet the health maintenance organization's

1 requirements for primary care physician participation; and

2 (2) agree to accept the responsibility to coordinate
3 all of the enrollee's health care needs. (V.T.I.C. Art. 20A.09,
4 Secs. (d), (g), as amended Acts 75th Leg., R.S., Ch. 905; (a)(3)
5 (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

6 Source Law

7 [Art. 20A.09, as amended Acts 75th Leg., R.S., Ch.
8 905]

9 (d) Each evidence of coverage must contain
10 provisions regarding the requirements adopted under
11 Subsections (e)-(i) of this section.

12 (g) An enrollee with a chronic, disabling, or
13 life-threatening illness may apply to the health
14 maintenance organization's medical director to use a
15 nonprimary care physician specialist as the enrollee's
16 primary care physician. An application made by an
17 enrollee under this subsection must include
18 information specified by the health maintenance
19 organization, including certification of the medical
20 need, and must be signed by the enrollee and the
21 nonprimary care physician specialist interested in
22 serving as the enrollee's primary care physician. To
23 be eligible to serve as the enrollee's primary care
24 physician, the specialist must:

25 (1) meet the health maintenance
26 organization's requirements for primary care physician
27 participation; and

28 (2) be willing to accept the coordination
29 of all of the enrollee's health care needs.

30 [Art. 20A.09, Sec. (a), as amended Acts 75th Leg.,
31 R.S., Ch. 1026]

32 [(3) An evidence of coverage shall
33 contain:]

34 . . .
35 (D) a provision to allow enrollees
36 with chronic, disabling, or life-threatening
37 illnesses to apply to the health maintenance
38 organization's medical director to utilize a
39 nonprimary care physician specialist as a primary care
40 physician, provided that:

41 (i) the request includes
42 information specified by the health maintenance
43 organization, including certification of medical
44 need, and is signed by the enrollee and the nonprimary
45 care physician specialist interested in serving as the
46 primary care physician;

47 (ii) the nonprimary care
48 physician specialist meets the health maintenance
49 organization's requirements for primary care physician
50 participation; and

51 (iii) the nonprimary care
52 physician specialist is willing to accept the
53 coordination of all of the enrollee's health care
54 needs;

55 . . .

56 Revised Law

57 Sec. 1271.202. APPEAL. If a health maintenance

1 organization denies a request under Section 1271.201, the enrollee
2 may appeal the decision through the health maintenance
3 organization's established complaint and appeals process.
4 (V.T.I.C. Art. 20A.09, Secs. (h), as amended Acts 75th Leg., R.S.,
5 Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

6 Source Law

7 (h) [as amended Acts 75th Leg., R.S., Ch. 905]
8 If the request for special consideration described by
9 Subsection (g) is denied, an enrollee may appeal the
10 decision through the health maintenance organization's
11 established complaint and appeals process.

12 (a) [as amended Acts 75th Leg., R.S., Ch. 1026]

13 . . .
14 (3) . . .
15 (E) a provision that if the request
16 for special consideration specified in Paragraph (D)
17 of this subdivision is denied, an enrollee may appeal
18 the decision through the health maintenance
19 organization's established complaint and appeals
20 process; and
21 . . .

22 Revised Law

23 Sec. 1271.203. EFFECTIVE DATE OF DESIGNATION. (a) The
24 effective date of the designation of a nonprimary care physician
25 specialist as an enrollee's primary care physician under Section
26 1271.201 may not be applied retroactively.

27 (b) A health maintenance organization may not reduce the
28 amount of compensation owed to the original primary care physician
29 for services provided before the date of the new designation.
30 (V.T.I.C. Art. 20A.09, Secs. (i), as amended Acts 75th Leg., R.S.,
31 Ch. 905; (a)(3) (part), as amended Acts 75th Leg., R.S., Ch. 1026.)

32 Source Law

33 (i) [as amended Acts 75th Leg., R.S., Ch. 905]
34 The effective date of the designation of a nonprimary
35 care physician specialist as an enrollee's primary
36 care physician, as provided by Subsection (g) of this
37 section, may not be applied retroactively. The health
38 maintenance organization may not reduce the amount of
39 compensation owed to the original primary care
40 physician for services provided before the date of the
41 new designation.

42 (a) [as amended Acts 75th Leg., R.S., Ch. 1026]

43 . . .
44 (3) . . .
45 (F) a provision that the effective
46 date of the new designation of a nonprimary care
47 physician specialist as set out in Paragraph (D) of

1 this subdivision shall not be retroactive; the health
2 maintenance organization may not reduce the amount of
3 compensation owed to the original primary care
4 physician prior to the date of the new designation.

5 [Sections 1271.204-1271.250 reserved for expansion]

6 SUBCHAPTER F. SCHEDULE OF CHARGES

7 Revised Law

8 Sec. 1271.251. APPROVAL OF FORMULA OR METHOD FOR COMPUTING
9 SCHEDULE OF CHARGES. (a) The formula or method for computing the
10 schedule of charges for enrollee coverage for health care services
11 must be filed with the commissioner before the formula or method is
12 used in conjunction with a health care plan.

13 (b) The formula or method must be established in accordance
14 with actuarial principles for the various categories of enrollees.
15 The filing of the method or formula must contain:

16 (1) a statement by a qualified actuary that certifies
17 that the formula or method is appropriate; and

18 (2) supporting information that the commissioner
19 considers adequate.

20 (c) The formula or method must produce charges that are not
21 excessive, inadequate, or unfairly discriminatory. Benefits must
22 be reasonable with respect to the rates produced by the formula or
23 method. (V.T.I.C. Art. 20A.09, Secs. (k) (part), as amended Acts
24 75th Leg., R.S., Ch. 905; (b) (part), as amended Acts 75th Leg.,
25 R.S., Ch. 1026.)

26 Source Law

27 (k) [as amended Acts 75th Leg., R.S., Ch. 905]
28 The formula or method for calculating the schedule of
29 charges for enrollee coverage for medical services or
30 health care services must be filed with the
31 commissioner before it is used in conjunction with any
32 health care plan. The formula or method must be
33 established in accordance with actuarial principles
34 for the various categories of enrollees. . . . The
35 formula or method must produce charges that are not
36 excessive, inadequate, or unfairly discriminatory,
37 and benefits must be reasonable with respect to the
38 rates produced by the formula or method. A statement
39 by a qualified actuary that certifies the
40 appropriateness of the formula or method must
41 accompany the filing together with supporting
42 information considered adequate by the commissioner.

43 (b) [as amended Acts 75th Leg., R.S., Ch. 1026]
44 The formula or method for calculating the schedule of

1 charges for enrollee coverage for medical services or
2 health care services must be filed with the
3 commissioner before it is used in conjunction with any
4 health care plan. The formula or method must be
5 established in accordance with actuarial principles
6 for the various categories of enrollees. . . . The
7 formula or method must produce charges that are not
8 excessive, inadequate, or unfairly discriminatory,
9 and benefits must be reasonable with respect to the
10 rates produced by the formula or method. A statement
11 by a qualified actuary that certifies the
12 appropriateness of the formula or method must
13 accompany the filing together with supporting
14 information considered adequate by the commissioner.

15 Revised Law

16 Sec. 1271.252. CONSIDERATION OF INDIVIDUAL HEALTH STATUS
17 PROHIBITED. The charges resulting from the application of a
18 formula or method described by Section 1271.251 may not be altered
19 for an individual enrollee based on the status of that enrollee's
20 health. (V.T.I.C. Art. 20A.09, Secs. (k) (part), as amended Acts
21 75th Leg., R.S., Ch. 905; (b) (part), as amended Acts 75th Leg.,
22 R.S., Ch. 1026.)

23 Source Law

24 (k) [as amended Acts 75th Leg., R.S., Ch.
25 905] . . . The charges resulting from the application
26 of the formula or method may not be altered for an
27 individual enrollee based on the status of that
28 enrollee's health. . . .

29 (b) [as amended Acts 75th Leg., R.S., Ch.
30 1026] . . . The charges resulting from the
31 application of the formula or method may not be altered
32 for an individual enrollee based on the status of that
33 enrollee's health. . . .

34 Revised Law

35 Sec. 1271.253. INFORMATION REQUIRED BY COMMISSIONER. The
36 commissioner may require the submission of any relevant information
37 the commissioner considers necessary in determining whether to
38 approve or disapprove a filing under this subchapter. (V.T.I.C.
39 Art. 20A.09, Secs. (m), as amended Acts 75th Leg., R.S., Ch. 905;
40 (d), as amended Acts 75th Leg., R.S., Ch. 1026.)

41 Source Law

42 (m) [as amended Acts 75th Leg., R.S., Ch. 905]
43 The commissioner may require the submission of
44 whatever relevant information he or she deems
45 necessary in determining whether to approve or
46 disapprove a filing made pursuant to this section.

47 (d) [as amended Acts 75th Leg., R.S., Ch. 1026]

1 The commissioner may require the submission of
2 whatever relevant information he or she deems
3 necessary in determining whether to approve or
4 disapprove a filing made pursuant to this section.

5 [Sections 1271.254-1271.300 reserved for expansion]

6 SUBCHAPTER G. CONTINUATION OF COVERAGE, CONVERSION
7 CONTRACTS, AND RENEWAL

8 Revised Law

9 Sec. 1271.301. ENTITLEMENT TO CONTINUATION OF GROUP
10 COVERAGE. (a) In this section, "involuntary termination for
11 cause" does not include termination for any health-related reason.

12 (b) A health maintenance organization shall provide a group
13 coverage continuation privilege as required by and subject to the
14 eligibility provisions of this subchapter.

15 (c) An enrollee is entitled to continue group coverage as
16 provided by this subchapter if:

17 (1) the enrollee's coverage under a group contract is
18 terminated for any reason except involuntary termination for cause;
19 and

20 (2) the enrollee for at least three consecutive months
21 immediately before the termination of coverage has been
22 continuously covered under the group contract and under any
23 previous group contract providing similar services and benefits
24 that the current group contract replaced. (V.T.I.C. Art. 20A.09,
25 Sec. (k)(A) (part), as added Acts 75th Leg., R.S., Ch. 837.)

26 Source Law

27 (k) Continuation of Coverage and Conversion.
28 (A) A health maintenance organization shall provide a
29 group continuation privilege as required by this
30 subsection. Any enrollee whose coverage under the
31 group contract has been terminated for any reason
32 except involuntary termination for cause, and who has
33 been continuously insured under the group contract and
34 under any group contract providing similar services
35 and benefits which it replaces for at least three
36 consecutive months immediately prior to termination
37 shall be entitled to such privilege as outlined below.
38 Involuntary termination for cause does not include
39 termination for any health-related cause. Health
40 maintenance organization contracts subject to this
41 section shall provide continuation of group coverage
42 for enrollees subject to the eligibility provisions
43 below:

44 . . .

1 Revised Law

2 Sec. 1271.302. REQUEST FOR CONTINUED COVERAGE;
3 DEADLINE. An enrollee must make a written election to continue
4 group coverage under this subchapter and pay the first contribution
5 required to establish contributions on an advance monthly basis to
6 the employer or group contract holder not later than the 31st day
7 after the later of:

8 (1) the date the group coverage would otherwise
9 terminate; or

10 (2) the date the enrollee is given notice of the right
11 of continuation by the employer or group contract holder.
12 (V.T.I.C. Art. 20A.09, Secs. (k)(A)(1), (3), as added Acts 75th
13 Leg., R.S., Ch. 837.)

14 Source Law

15 (1) Continuation of group coverage
16 must be requested in writing within 31 days following
17 the later of: (aa) the date the group coverage would
18 otherwise terminate; or (bb) the date the enrollee is
19 given notice of the right of continuation by either the
20 employer or the group contract holder.

21 (3) The enrollee's written election
22 of continuation, together with the first contribution
23 required to establish contributions on a monthly
24 basis, in advance, must be given to the contract holder
25 or employer within 31 days following the later of:
26 (aa) the date the group coverage would otherwise
27 terminate; or (bb) the date the enrollee is given
28 notice of the right of continuation by either the
29 employer or the group contract holder.

30 Revised Law

31 Sec. 1271.303. PAYMENT FOR CONTINUED COVERAGE. (a) An
32 enrollee electing continuation of group coverage must pay to the
33 employer or group contract holder the amount of contribution
34 required by the employer or group contract holder, plus an amount
35 equal to two percent of the group rate for the coverage being
36 continued under the group contract.

37 (b) The enrollee must make the payment in advance on a
38 monthly basis on the due date of each payment. (V.T.I.C. Art.
39 20A.09, Sec. (k)(A)(2), as added Acts 75th Leg., R.S., Ch. 837.)

1 Insurance Risk Pool as provided by Chapter 1506.

2 (b) The health maintenance organization shall provide to
3 the enrollee the address for applying to the pool for coverage.
4 (V.T.I.C. Art. 20A.09, Sec. (k)(A)(5), as added Acts 75th Leg.,
5 R.S., Ch. 837.)

6 Source Law

7 (5) Not less than 30 days before the
8 end of the six months after the date the enrollee
9 elects continuation of the contract, the health
10 maintenance organization shall notify the enrollee
11 that he/she may be eligible for coverage under the
12 Texas Health Insurance Risk Pool, as provided under
13 Article 3.77, Insurance Code, and the health
14 maintenance organization shall provide the address for
15 applying to such pool to the enrollee.

16 Revised Law

17 Sec. 1271.306. CONVERSION CONTRACTS. (a) A health
18 maintenance organization may offer to each enrollee a conversion
19 contract.

20 (b) A health maintenance organization shall issue the
21 conversion contract without evidence of insurability if written
22 application for the contract and payment of the first premium are
23 made not later than the 31st day after the date of termination of
24 coverage.

25 (c) A conversion contract must meet the minimum standards
26 for services and benefits for conversion contracts. The
27 commissioner shall adopt rules to prescribe the minimum standards
28 for services and benefits applicable to conversion contracts.

29 (d) The premium for a conversion contract shall be
30 determined in accordance with the health maintenance
31 organization's premium rates for coverage provided under the group
32 contract or plan. The premium may be based on the geographic
33 location of each person to be covered and must be based on the type
34 of conversion contract and the coverage provided by the contract.
35 The premium may not exceed 200 percent of the premium rates for the
36 same coverage provided under a group contract or plan. (V.T.I.C.
37 Art. 20A.09, Secs. (k)(B), (C), as added Acts 75th Leg., R.S., Ch.
38 837.)

1 Source Law

2 (B) A health maintenance organization may
3 offer to each enrollee a conversion contract. Such
4 conversion contract shall be issued without evidence
5 of insurability if written application for and payment
6 of the first premium is made not later than the 31st
7 day after the date of termination. The conversion
8 contract shall meet the minimum standards for services
9 and benefits for conversion contracts. The
10 commissioner shall issue rules and regulations to
11 establish minimum standards for services and benefits
12 under contracts issued pursuant to this subdivision.

13 (C) The premium for a conversion contract
14 issued under this Act shall be determined in
15 accordance with the health maintenance organization's
16 premium rates for coverage that were provided under
17 the group contract or plan. The premium may be based
18 on geographic location of each person to be covered and
19 the type of conversion contract and coverage provided.
20 The premium for the same coverage under a conversion
21 contract may not exceed 200 percent of the premium
22 determined in accordance with this subdivision. The
23 premium must be based on the type of conversion
24 contract and the coverage provided by contract.

25 Revisor's Note

26 Section (k)(B), V.T.I.C. Article 20A.09, refers
27 to "rules and regulations." The revised law omits the
28 reference to "regulations" because under Section
29 311.005(5), Government Code (Code Construction Act), a
30 rule is defined to include a regulation. That
31 definition applies to the revised law.

32 Revised Law

33 Sec. 1271.307. RENEWABILITY OF COVERAGE: INDIVIDUAL HEALTH
34 CARE PLANS AND CONVERSION CONTRACTS. (a) In this section,
35 "individual health care plan" has the meaning assigned by Section
36 1271.004.

37 (b) An individual health care plan or a conversion contract
38 that provides health care services to an enrollee is renewable at
39 the option of the enrollee. A health maintenance organization may
40 decline to renew an individual health care plan or conversion
41 contract only:

42 (1) for failure to pay premiums or contributions in
43 accordance with the terms of the plan or because the issuer of the
44 plan has not received timely premium payments;

45 (2) for fraud or intentional misrepresentation;

1 (3) because the health maintenance organization
2 ceases to offer coverage in the individual market in accordance
3 with rules established by the commissioner;

4 (4) because the enrollee no longer resides or works in
5 the area in which the health maintenance organization is authorized
6 to provide coverage, if coverage under the plan is terminated
7 uniformly for this reason without regard to any factor related to
8 the health status of a covered enrollee; or

9 (5) in accordance with applicable federal law,
10 including regulations.

11 (c) The commissioner may adopt rules necessary to implement
12 this section and to meet the minimum requirements of federal law,
13 including regulations. (V.T.I.C. Art. 20A.09, Sec. (1) (part), as
14 added Acts 75th Leg., R.S., Ch. 837.)

15 Source Law

16 (1)

17 (A) For purposes of this subsection, an
18 "individual health care plan" means:

19 (1) a health care plan providing
20 health care services for individuals and their
21 dependents;

22 (2) a health care plan in which an
23 enrollee pays the premium and is not being covered
24 under the contract pursuant to continuation of
25 services and benefits provisions applicable under
26 federal or state law; and

27 (3) a plan in which the evidence of
28 coverage meets the requirements of Section 2(a) of
29 this Act.

30

31 (C) Renewability of Coverage. An
32 individual health care plan or a conversion contract
33 providing health care services shall be renewable with
34 respect to an enrollee at the option of the enrollee,
35 and may be nonrenewed based only on one or more of the
36 following reasons:

37 (1) failure to pay premiums or
38 contributions in accordance with the terms of the plan
39 or the issuer has not received timely premium
40 payments;

41 (2) fraud or intentional
42 misrepresentation;

43 (3) the health maintenance
44 organization is ceasing to offer coverage in the
45 individual market in accordance with rules established
46 by the commissioner;

47 (4) enrollee no longer resides,
48 lives, or works in the area in which the health
49 maintenance organization is authorized to provide
50 coverage, but only if such coverage is terminated
51 under this paragraph uniformly without regard to any
52 health-status-related factor of covered enrollees; or

1 (5) in accordance with applicable
2 federal law and regulations.

3 (D) The commissioner may adopt rules
4 necessary to implement this subsection and to meet the
5 minimum requirements of federal law and regulations.

6 CHAPTER 1272. DELEGATION OF CERTAIN FUNCTIONS BY HEALTH
7 MAINTENANCE ORGANIZATION

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31 [Sections 1272.212-1272.250 reserved for expansion]

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8 [Sections 1272.256-1272.300 reserved for expansion]

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13 CHAPTER 1272. DELEGATION OF CERTAIN FUNCTIONS BY HEALTH
14 MAINTENANCE ORGANIZATION

15 SUBCHAPTER A. GENERAL PROVISIONS

16 Revised Law

17 Sec. 1272.001. DEFINITIONS. (a) In this chapter:

18 (1) "Delegated entity" means an entity, other than a
19 health maintenance organization authorized to engage in business
20 under Chapter 843, that by itself, or through subcontracts with one
21 or more entities, undertakes to arrange for or provide medical care
22 or health care to an enrollee in exchange for a predetermined
23 payment on a prospective basis and that accepts responsibility for
24 performing on behalf of the health maintenance organization a
25 function regulated by this chapter, Chapter 843, 1271, or 1367, or
26 Subchapter A, Chapter 1452. The term does not include:

27 (A) an individual physician; or

28 (B) a group of employed physicians, practicing
29 medicine under one federal tax identification number, whose total
30 claims paid to providers not employed by the group constitute less
31 than 20 percent of the group's total collected revenue computed on a
32 calendar year basis.

33 (2) "Delegated network" means a delegated entity that
34 assumes total financial risk for more than one of the following

1 categories of health care services: medical care, hospital or other
2 institutional services, or prescription drugs, as defined by
3 Section 551.003, Occupations Code. The term does not include a
4 delegated entity that shares risk for a category of services with a
5 health maintenance organization.

6 (3) "Delegated third party" means a third party other
7 than a delegated entity that contracts with a delegated entity,
8 either directly or through another third party, to:

9 (A) accept responsibility for performing a
10 function regulated by this chapter, Chapter 843, 1271, or 1367, or
11 Subchapter A, Chapter 1452; or

12 (B) receive, handle, or administer funds, if the
13 receipt, handling, or administration is directly or indirectly
14 related to a function regulated by this chapter, Chapter 843, 1271,
15 or 1367, or Subchapter A, Chapter 1452.

16 (4) "Delegation agreement" means an agreement by which
17 a health maintenance organization assigns the responsibility for a
18 function regulated by this chapter, Chapter 843, 1271, or 1367, or
19 Subchapter A, Chapter 1452.

20 (5) "Limited provider network" means a subnetwork
21 within a health maintenance organization delivery network in which
22 contractual relationships exist between physicians, certain
23 providers, independent physician associations, or physician groups
24 that limits an enrollee's access to physicians and providers to
25 those physicians and providers in the subnetwork.

26 (b) In this chapter, terms defined by Section 843.002 have
27 the meanings assigned by that section. (V.T.I.C. Art. 20A.02,
28 Secs. (dd), (ee), (ff), (gg), (hh); New.)

29 Source Law

30 (dd) "Delegation agreement" means an
31 agreement by which a health maintenance organization
32 assigns the responsibility for a function regulated
33 under this Act.

34 (ee) "Delegated entity" means an entity,
35 other than a health maintenance organization
36 authorized to do business under this Act, that by
37 itself, or through subcontracts with one or more
38 entities, undertakes to arrange for or to provide

1 medical care or health care to an enrollee in exchange
2 for a predetermined payment on a prospective basis and
3 that accepts responsibility to perform on behalf of
4 the health maintenance organization any function
5 regulated by this Act. The term does not include an
6 individual physician or a group of employed physicians
7 practicing medicine under one federal tax
8 identification number and whose total claims paid to
9 providers not employed by the group is less than 20
10 percent of the total collected revenue of the group
11 calculated on a calendar year basis.

12 (ff) "Delegated network" means any
13 delegated entity that assumes total financial risk for
14 more than one of the following categories of health
15 care services: medical care, hospital or other
16 institutional services, or prescription drugs, as
17 defined by Section 551.003, Occupations Code. The
18 term does not include a delegated entity that shares
19 risk for a category of services with a health
20 maintenance organization.

21 (gg) "Delegated third party" means a third
22 party other than a delegated entity that contracts
23 with a delegated entity, either directly or through
24 another third party, to:

25 (1) accept responsibility to perform
26 any function regulated by this Act; or

27 (2) receive, handle, or administer
28 funds, if the receipt, handling, or administration of
29 the funds is directly or indirectly related to a
30 function regulated by this Act.

31 (hh) "Limited provider network" means a
32 subnetwork within a health maintenance organization
33 delivery network in which contractual relationships
34 exist between physicians, certain providers,
35 independent physician associations, or physician
36 groups that limits the physicians and providers to
37 which the enrollees have access to physicians and
38 providers in the subnetwork.

39 Revisor's Note

40 (1) This chapter is derived from V.T.I.C.
41 Articles 20A.02, 20A.18C, 20A.18D, 20A.18E, 20A.18F,
42 and 20A.18G, which are parts of the Texas Health
43 Maintenance Organization Act. Most provisions of the
44 Texas Health Maintenance Organization Act, including
45 the definitional provisions that apply throughout the
46 act, are revised in Chapter 843 of this code.
47 Accordingly, this chapter includes a reference to the
48 applicability of the definitions provided by Section
49 843.002 of this code.

50 (2) Sections (dd), (ee), and (gg), V.T.I.C.
51 Article 20A.02, refer to any "function regulated under
52 this Act" or any "function regulated by this Act,"
53 meaning any function regulated under the Texas Health

1 Maintenance Organization Act (V.T.I.C. Chapter 20A).
2 A majority of V.T.I.C. Chapter 20A was revised in 2001
3 as Chapter 843 of this code. Additional portions of
4 Chapter 20A are revised in this chapter. The remaining
5 portions of Chapter 20A are revised in this code in
6 Chapters 222 and 258, which impose premium and
7 maintenance taxes on health maintenance
8 organizations; Chapter 1271, which deals with various
9 benefits provided by health maintenance
10 organizations; Chapter 1367, in part, which requires
11 health maintenance organizations to provide coverage
12 for certain childhood immunizations; and Chapter 1452,
13 in part, which deals with credentialing of physicians
14 and providers by health maintenance organizations.
15 Accordingly, throughout this chapter the revised law
16 substitutes references to the specified chapters for
17 references to "this Act." However, because the issue
18 of taxes is irrelevant to the delegation of a function
19 under this chapter, the revised law throughout this
20 chapter does not refer to Chapter 222 or 258 of this
21 code.

22 Revised Law

23 Sec. 1272.002. COMPLIANCE OF LIMITED PROVIDER NETWORK OR
24 DELEGATED ENTITY WITH CERTAIN LEGAL REQUIREMENTS. A limited
25 provider network or delegated entity shall comply with each
26 statutory or regulatory requirement that relates to a function
27 assumed by or carried out by the network or entity under this
28 chapter. (V.T.I.C. Art. 20A.18G.)

29 Source Law

30 Art. 20A.18G. A limited provider network or
31 delegated entity shall comply with all statutory and
32 regulatory requirements relating to any function,
33 duty, responsibility, or delegation assumed by or
34 carried out by the limited provider network or
35 delegated entity under this Act.

1 Revisor's Note

2 V.T.I.C. Article 20A.18G refers to a "function,
3 duty, responsibility, or delegation" assumed by or
4 carried out by a limited provider network or delegated
5 entity under "this Act," meaning the Texas Health
6 Maintenance Organization Act. Throughout this
7 chapter, the revised law omits as unnecessary
8 references to a "duty, responsibility, or delegation"
9 because, in this context, a "function" assumed by or
10 carried out by a limited provider network or delegated
11 entity under that act includes a duty, responsibility,
12 or delegation assumed by or carried out by the network
13 or entity. The revised law also substitutes a
14 reference to "this chapter" for the reference to the
15 Texas Health Maintenance Organization Act because the
16 law revised in this chapter is the relevant part of
17 that act under which a limited provider or delegated
18 entity may assume or carry out a function of a health
19 maintenance organization.

20 [Sections 1272.003-1272.050 reserved for expansion]

21 SUBCHAPTER B. DELEGATION AGREEMENTS

22 Revised Law

23 Sec. 1272.051. APPLICABILITY OF SUBCHAPTER. This
24 subchapter does not apply to a group model health maintenance
25 organization, as defined by Section 843.111. (V.T.I.C. Art.
26 20A.18C, Sec. (q).)

27 Source Law

28 (q) This section does not apply to a group model
29 health maintenance organization, as defined by Section
30 6A of this Act.

31 Revised Law

32 Sec. 1272.052. DELEGATION AGREEMENT REQUIRED. (a) A
33 health maintenance organization that delegates a function required
34 by this chapter, Chapter 843, 1271, or 1367, or Subchapter A,
35 Chapter 1452, shall execute a written delegation agreement with the

1 entity to which the function is delegated.

2 (b) The health maintenance organization shall file the
3 delegation agreement with the department not later than the 30th
4 day after the date the agreement is executed.

5 (c) The parties to the delegation agreement shall determine
6 which party bears the expense of complying with a requirement of
7 this subchapter, including the cost of an examination required by
8 the department under Article 1.15, if applicable. (V.T.I.C. Art.
9 20A.18C, Sec. (a) (part).)

10 Source Law

11 Art. 20A.18C. (a) A health maintenance
12 organization that delegates any function required by
13 this Act shall execute a written agreement with each
14 delegated entity. The health maintenance organization
15 shall file the written agreement with the Texas
16 Department of Insurance not later than the 30th day
17 after the date the agreement is executed. The parties
18 to each agreement shall determine the party that will
19 bear the expense of compliance with any requirement of
20 this subsection, including the cost of any
21 examinations required by the department under Article
22 1.15, Insurance Code, if applicable. . . .

23 Revisor's Note

24 Section (a), V.T.I.C. Article 20A.18C, requires a
25 health maintenance organization that delegates
26 certain functions to execute a "written agreement"
27 with each delegated entity. The revised law
28 substitutes a reference to "delegation agreement" for
29 the reference to "agreement" because "delegation
30 agreement" is the defined term used throughout this
31 chapter to describe the contract between a health
32 maintenance organization and a delegated entity or
33 other entity or party to whom the health maintenance
34 organization delegates certain functions. Similar
35 changes have been made throughout this chapter.

36 Revised Law

37 Sec. 1272.053. MONITORING PLAN. A delegation agreement
38 required by Section 1272.052 must establish a monitoring plan that:

39 (1) allows the health maintenance organization to

1 monitor compliance with the minimum solvency requirements
2 established under Subchapter D, if applicable; and

3 (2) includes:

4 (A) a description of financial practices that
5 will ensure that the delegated entity tracks and reports
6 liabilities that have been incurred but not reported;

7 (B) a summary of the total amount paid by the
8 entity to physicians and providers on a monthly basis; and

9 (C) a summary of complaints from physicians,
10 providers, and enrollees regarding delays in payment or nonpayment
11 of claims, including the status of each complaint, on a monthly
12 basis. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

13 Source Law

14 (a) . . . The written agreement must contain:

15 (1) a monitoring plan that allows the
16 health maintenance organization to monitor compliance
17 with the minimum solvency requirements established
18 under Section 18D of this Act, if applicable, and that
19 includes:

20 (A) a description of financial
21 practices that will ensure that the delegated entity
22 tracks and reports liabilities that have been incurred
23 but not reported;

24 (B) a summary of the total amount
25 paid by the delegated entity to physicians and
26 providers on a monthly basis; and

27 (C) a summary of complaints from
28 physicians, enrollees, and providers regarding delays
29 in payments of claims or nonpayment of claims,
30 including the status of each complaint, on a monthly
31 basis;

32 . . .

33 Revised Law

34 Sec. 1272.054. REQUIREMENTS FOR TERMINATION WITHOUT
35 CAUSE. A delegation agreement required by Section 1272.052 must
36 provide that the agreement cannot be terminated without cause by
37 the delegated entity or the health maintenance organization unless
38 the party terminating the agreement provides written notice before
39 the 90th day before the termination date. (V.T.I.C. Art. 20A.18C,
40 Sec. (a) (part).)

41 Source Law

42 (a) . . . The written agreement must contain:

43 . . .

44 (2) A provision that the agreement cannot

1 be terminated without cause by the delegated entity or
2 the health maintenance organization without written
3 notice provided before the 90th day preceding the
4 termination date;

5 . . .

6 Revised Law

7 Sec. 1272.055. COLLECTION OF PAYMENTS. A delegation
8 agreement required by Section 1272.052 must prohibit the delegated
9 entity and the physicians and providers with whom the entity has
10 contracted from billing or attempting to collect from an enrollee
11 under any circumstance, including the insolvency of the health
12 maintenance organization or entity, payments for covered services
13 other than authorized copayments and deductibles. (V.T.I.C. Art.
14 20A.18C, Sec. (a) (part).)

15 Source Law

16 (a) . . . The written agreement must contain:

17 . . .

18 (3) a provision that prohibits the
19 delegated entity and the physicians and providers with
20 whom it has contracted from billing or attempting to
21 collect from an enrollee under any circumstance,
22 including the insolvency of the health maintenance
23 organization or delegated entity, payments for covered
24 services other than authorized copayments and
25 deductibles;

26 . . .

27 Revised Law

28 Sec. 1272.056. COMPLIANCE WITH STATUTORY AND REGULATORY
29 REQUIREMENTS. A delegation agreement required by Section 1272.052
30 must provide that:

31 (1) the agreement does not limit in any way the health
32 maintenance organization's authority or responsibility, including
33 financial responsibility, to comply with each statutory or
34 regulatory requirement; and

35 (2) the delegated entity shall comply with each
36 statutory or regulatory requirement relating to a function assumed
37 by or carried out by the entity. (V.T.I.C. Art. 20A.18C, Sec. (a)
38 (part).)

39 Source Law

40 (a) . . . The written agreement must contain:

41 . . .

42 (4) a provision that the delegation
43 agreement may not be construed to limit in any way the

1 health maintenance organization's authority or
2 responsibility, including financial responsibility,
3 to comply with all statutory and regulatory
4 requirements;

5 (5) a provision that requires the
6 delegated entity to comply with all statutory and
7 regulatory requirements relating to any function,
8 duty, responsibility, or delegation assumed by or
9 carried out by the delegated entity;

10 . . .

11 Revised Law

12 Sec. 1272.057. EXAMINATION BY COMMISSIONER. A delegation
13 agreement required by Section 1272.052 must require the delegated
14 entity to permit the commissioner to examine at any time any
15 information the commissioner reasonably believes is relevant to:

16 (1) the financial solvency of the entity; or

17 (2) the ability of the entity to meet the entity's
18 responsibilities in connection with any function delegated to the
19 entity by the health maintenance organization. (V.T.I.C. Art.
20 20A.18C, Sec. (a) (part).)

21 Source Law

22 (a) . . . The written agreement must contain:

23 . . .

24 (6) a provision that requires the
25 delegated entity to permit the commissioner to examine
26 at any time any information the commissioner
27 reasonably believes is relevant to:

28 (A) the financial solvency of the
29 delegated entity; or

30 (B) the ability of the delegated
31 entity to meet the entity's responsibilities in
32 connection with any function delegated to the entity
33 by the health maintenance organization;

34 . . .

35 Revised Law

36 Sec. 1272.058. INFORMATION RELATING TO DELEGATED THIRD
37 PARTY. A delegation agreement required by Section 1272.052 must
38 require the delegated entity to provide the license number of a
39 delegated third party performing a function that requires:

40 (1) a license as a third-party administrator under
41 Chapter 4151 or utilization review agent under Article 21.58A; or

42 (2) another license under this code or another
43 insurance law of this state. (V.T.I.C. Art. 20A.18C, Sec. (a)
44 (part).)

1 (1) enrollees shall receive notification at the time
2 of enrollment of which entity is responsible for performing
3 utilization review;

4 (2) the delegated entity or third party performing
5 utilization review shall perform that review in accordance with
6 Article 21.58A; and

7 (3) the delegated entity or third party shall forward
8 utilization review decisions made by the entity or third party to
9 the health maintenance organization on a monthly basis. (V.T.I.C.
10 Art. 20A.18C, Sec. (a) (part).)

11 Source Law

12 (a) . . . The written agreement must contain:

13 . . .

14 (8) a provision that requires that:

15 (A) enrollees will receive
16 notification at the time of enrollment which entity
17 has responsibility for performing utilization review;

18 (B) the delegated entity or third
19 party performing utilization review shall do so in
20 accordance with Article 21.58A, Insurance Code; and

21 (C) utilization review decisions
22 made by the delegated entity or a third party shall be
23 forwarded to the health maintenance organization on a
24 monthly basis;

25 . . .

26 Revised Law

27 Sec. 1272.061. RIGHTS AND DUTIES OF DELEGATED ENTITY AND
28 HEALTH MAINTENANCE ORGANIZATION. A delegation agreement required
29 by Section 1272.052 must provide that the delegated entity
30 acknowledges and agrees that:

31 (1) the health maintenance organization:

32 (A) is required to establish, operate, and
33 maintain a health care delivery system, quality assurance system,
34 provider credentialing system, and other systems and programs that
35 meet statutory and regulatory standards;

36 (B) is directly accountable for compliance with
37 those standards; and

38 (C) is not precluded from contractually
39 requesting that the delegated entity provide proof of financial
40 viability;

1 (2) the role of another delegated entity with which
2 the delegated entity subcontracts through a delegated third party
3 is limited to performing certain delegated functions of the health
4 maintenance organization, using standards that are approved by the
5 health maintenance organization and that are in compliance with
6 applicable statutes and rules and subject to the health maintenance
7 organization's oversight and monitoring of the entity's
8 performance; and

9 (3) if the delegated entity fails to meet monitoring
10 standards established to ensure that functions delegated or
11 assigned to the entity under the delegation agreement are in full
12 compliance with all statutory and regulatory requirements, the
13 health maintenance organization may cancel delegation of any or all
14 delegated functions. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

15 Source Law

16 (a) . . . The written agreement must contain:

17 . . .
18 (11) an acknowledgment and agreement by
19 the delegated entity that:

20 (A) the health maintenance
21 organization is:

22 (i) required to establish,
23 operate, and maintain a health care delivery system,
24 quality assurance system, provider credentialing
25 system, and other systems and programs that meet
26 statutory and regulatory standards;

27 (ii) directly accountable for
28 compliance with those standards; and

29 (iii) not precluded from
30 contractually requesting that the delegated entity
31 provide proof of financial viability;

32 (B) the role of any delegated entity
33 with which it subcontracts through a delegated third
34 party is limited to performing certain delegated
35 functions of the health maintenance organization,
36 using standards that are approved by the health
37 maintenance organization and that are in compliance
38 with applicable statutes and rules and subject to the
39 health maintenance organization's oversight and
40 monitoring of the delegated entity's performance; and

41 (C) if the delegated entity fails to
42 meet monitoring standards established to ensure that
43 functions delegated or assigned to the entity under
44 the delegation contract are in full compliance with
45 all statutory and regulatory requirements, the health
46 maintenance organization may cancel delegation of any
47 or all delegated functions;

48 . . .

49 Revised Law

50 Sec. 1272.062. INFORMATION TO BE PROVIDED BY DELEGATED

1 ENTITY TO HEALTH MAINTENANCE ORGANIZATION. (a) A delegation
2 agreement required by Section 1272.052 must provide that:

3 (1) except as provided by Subsection (b), the
4 delegated entity shall make available to the health maintenance
5 organization samples of contracts with physicians and providers to
6 ensure compliance with the contractual requirements described by
7 Sections 1272.054 and 1272.055; and

8 (2) the delegated entity shall provide to the health
9 maintenance organization, in a format usable for audit purposes and
10 not more frequently than quarterly unless otherwise specified in
11 the delegation agreement, the data necessary for the health
12 maintenance organization to comply with the department's reporting
13 requirements with respect to any delegated functions performed
14 under the delegation agreement, including:

15 (A) a summary describing the methods, including
16 capitation, fee-for-service, or other risk arrangements, that the
17 delegated entity used to pay the entity's physicians and providers,
18 and including the percentage of physicians and providers paid for
19 each payment category;

20 (B) the period that claims and debts for medical
21 services owed by the delegated entity have been pending and the
22 aggregate dollar amount of those claims and debts;

23 (C) information to enable the health maintenance
24 organization to file claims for reinsurance, coordination of
25 benefits, and subrogation, if required by the delegation agreement;
26 and

27 (D) documentation, except for information,
28 documents, and deliberations related to peer review that are
29 confidential or privileged under Subchapter A, Chapter 160,
30 Occupations Code, that relates to:

31 (i) a regulatory agency's inquiry or
32 investigation of the delegated entity or an individual physician or
33 provider with whom the entity contracts that relates to an enrollee
34 of the health maintenance organization; and

1 (ii) the final resolution of a regulatory
2 agency's inquiry or investigation.

3 (b) A delegation agreement may not require a delegated
4 entity to make available to the health maintenance organization
5 contractual provisions relating to financial arrangements with the
6 entity's physicians and providers. (V.T.I.C. Art. 20A.18C, Sec.
7 (a) (part).)

8 Source Law

9 (a) . . . The written agreement must contain:

10 . . .
11 (12) a provision that requires the
12 delegated entity to make available to the health
13 maintenance organization samples of contracts with
14 physicians and providers to ensure compliance with the
15 contractual requirements described by Subdivisions
16 (2) and (3) of this subsection, except that the
17 agreement may not require that the delegated entity
18 make available to the health maintenance organization
19 contractual provisions relating to financial
20 arrangements with the delegated entity's physicians
21 and providers;

22 (13) a provision that requires the
23 delegated entity to provide the health maintenance
24 organization, in a usable format necessary for audit
25 purposes and at most quarterly unless otherwise
26 specified in the agreement, the data necessary for the
27 health maintenance organization to comply with the
28 department's reporting requirements with respect to
29 any delegated functions performed under the delegation
30 agreement, including:

31 (A) a summary:

32 (i) describing the methods,
33 including capitation, fee-for-service, or other risk
34 arrangements, that the delegated entity used to pay
35 its physicians and providers; and

36 (ii) including the percentage
37 of physicians and providers paid for each payment
38 category;

39 (B) the period that claims and debts
40 for medical services owed by the delegated entity have
41 been pending and the aggregate dollar amount of those
42 claims and debts;

43 (C) information that will enable the
44 health maintenance organization to file claims for
45 reinsurance, coordination of benefits, and
46 subrogation, if required by the health maintenance
47 organization's contract with the delegated entity; and

48 (D) documentation, except for
49 information, documents, and deliberations related to
50 peer review that are confidential or privileged under
51 Subchapter A, Chapter 160, Occupations Code, that
52 relates to:

53 (i) a regulatory agency's
54 inquiry or investigation of the delegated entity or of
55 an individual physician or provider with whom the
56 delegated entity contracts that relates to an enrollee
57 of the health maintenance organization; and

58 (ii) the final resolution of a
59 regulatory agency's inquiry or investigation; and

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Revised Law

Sec. 1272.063. ENROLLEE COMPLAINTS. (a) A delegation agreement required by Section 1272.052 must provide that:

(1) if the delegated entity receives a complaint that does not involve emergency care, the entity shall report the complaint to the health maintenance organization not later than the second business day after the date the entity receives the complaint; and

(2) if the delegated entity receives a complaint involving emergency care, the entity shall immediately forward the complaint to the health maintenance organization.

(b) Subsection (a) does not prohibit a delegated entity from attempting to resolve a complaint. (V.T.I.C. Art. 20A.18C, Sec. (a) (part).)

Source Law

(a) . . . The written agreement must contain:

(14) a provision relating to enrollee complaints that requires the delegated entity to ensure that upon receipt of a complaint, as defined by this Act, the delegated entity shall report the complaint to the health maintenance organization within two business days, except that in a case in which a complaint involves emergency care, as defined in this Act, the delegated entity shall forward the complaint immediately to the health maintenance organization, and provided that nothing in this subdivision prohibits the delegated entity from attempting to resolve a complaint.

Revisor's Note

Section (a)(14), V.T.I.C. Article 20A.18C, refers to the definitions of "complaint" and "emergency care" in the Texas Health Maintenance Organization Act. The revised law omits the references to those definitions as unnecessary because the relevant part of that act was codified as Section 843.002, which applies to this chapter. See Section 1272.001(b) and Revisor's Note (1) to that section.

Revised Law

Sec. 1272.064. RULES. The commissioner may adopt rules as

1 necessary to implement this subchapter. (V.T.I.C. Art. 20A.18C,
2 Sec. (r).)

3 Source Law

4 (r) The commissioner may adopt rules as
5 necessary to implement this section.

6 [Sections 1272.065-1272.100 reserved for expansion]

7 SUBCHAPTER C. INFORMATION REPORTING TO DELEGATED ENTITY

8 Revised Law

9 Sec. 1272.101. APPLICABILITY OF SUBCHAPTER. This
10 subchapter does not apply to a group model health maintenance
11 organization, as defined by Section 843.111. (V.T.I.C. Art.
12 20A.18C, Sec. (q).)

13 Source Law

14 (q) This section does not apply to a group model
15 health maintenance organization, as defined by Section
16 6A of this Act.

17 Revised Law

18 Sec. 1272.102. REPORTING REQUIRED. (a) The commissioner
19 shall determine the information a health maintenance organization
20 shall provide to a delegated entity with which the health
21 maintenance organization has entered into a delegation agreement.

22 (b) The information must include:

23 (1) for each enrollee who is eligible or assigned to
24 receive services from the delegated entity:

25 (A) the enrollee's name, birth date or social
26 security number, age, and sex;

27 (B) the benefit plan and any riders to that plan
28 that are applicable to the enrollee; and

29 (C) the enrollee's employer;

30 (2) the name and birth date or social security number
31 of each enrollee added or terminated since the health maintenance
32 organization last provided the information;

33 (3) if the health maintenance organization pays any
34 claims on behalf of the delegated entity, a summary of the number
35 and amount of:

1 (A) claims paid during the previous reporting
2 period; and

3 (B) pharmacy prescriptions paid for each
4 enrollee during the previous reporting period for which the
5 delegated entity has taken partial risk;

6 (4) information that enables the delegated entity to
7 file claims for reinsurance, coordination of benefits, and
8 subrogation;

9 (5) patient complaint data that relates to the
10 delegated entity;

11 (6) detailed risk-pool data, reported quarterly and on
12 settlement;

13 (7) if hospital or facility costs impact the delegated
14 entity's costs, the percent of premium attributable to hospital or
15 facility costs, reported quarterly; and

16 (8) if there are changes in hospital or facility
17 contracts with the health maintenance organization, the projected
18 impact of those changes on the percent of premium attributable to
19 hospital and facility costs during the 30-day period following
20 those changes.

21 (c) Notwithstanding Subsection (b)(3), a delegated entity
22 may, on request, receive additional nonproprietary information
23 regarding claims paid by a health maintenance organization on
24 behalf of the entity.

25 (d) A health maintenance organization shall provide
26 information required under Subsections (b)(1)-(5) in standard
27 electronic format at least monthly unless the delegation agreement
28 provides otherwise. (V.T.I.C. Art. 20A.18C, Secs. (b), (c).)

29 Source Law

30 (b) The commissioner shall determine the
31 information that a health maintenance organization
32 shall provide to each delegated entity with which the
33 health maintenance organization has a delegation
34 agreement. The information must include the following
35 information, provided in standard electronic format at
36 least monthly unless otherwise stated in the
37 agreement:

38 (1) the names and dates of birth or social

1 security numbers of the enrollees of the health
2 maintenance organization who are eligible or assigned
3 to receive services from the delegated entity,
4 including the enrollees added and terminated since the
5 previous reporting period;

6 (2) the age, sex, benefit plan and any
7 riders to that benefit plan, and employer for the
8 enrollees of the health maintenance organization who
9 are eligible or assigned to receive services from the
10 delegated entity;

11 (3) if the health maintenance organization
12 pays any claims for the delegated entity, a summary of
13 the number and amount of claims paid by the health
14 maintenance organization on behalf of the delegated
15 entity during the previous reporting period, provided
16 that a delegated entity is not precluded from
17 receiving, upon request, additional nonproprietary
18 information regarding such claims;

19 (4) if the health maintenance organization
20 pays any claims for the delegated entity, a summary of
21 the number and amount of pharmacy prescriptions paid
22 for each enrollee for which the delegated entity has
23 taken partial risk during the previous reporting
24 period, provided that a delegated entity is not
25 precluded from receiving, upon request, additional
26 nonproprietary information regarding such claims;

27 (5) information that enables the delegated
28 entity to file claims for reinsurance, coordination of
29 benefits, and subrogation; and

30 (6) patient complaint data that relates to
31 the delegated entity.

32 (c) In addition to the information required by
33 Subsection (b) of this section, a health maintenance
34 organization shall provide to a delegated entity:

35 (1) detailed risk-pool data, reported
36 quarterly and on settlement; and

37 (2) the percent of premium attributable to
38 hospital or facility costs, if hospital or facility
39 costs impact the delegated entity's costs, reported
40 quarterly, and, if there are changes in hospital or
41 facility contracts with the health maintenance
42 organization, the projected impact of those changes on
43 the percent of premium attributable to hospital and
44 facility costs within 30 days of such changes.

45 Revised Law

46 Sec. 1272.103. RULES. The commissioner may adopt rules as
47 necessary to implement this subchapter. (V.T.I.C. Art. 20A.18C,
48 Sec. (r).)

49 Source Law

50 (r) The commissioner may adopt rules as
51 necessary to implement this section.

52 [Sections 1272.104-1272.150 reserved for expansion]

53 SUBCHAPTER D. RESERVE REQUIREMENTS

54 Revised Law

55 Sec. 1272.151. APPLICABILITY OF SUBCHAPTER. This
56 subchapter does not apply to a group model health maintenance

1 organization, as defined by Section 843.111. (V.T.I.C. Art.
2 20A.18D, Sec. (h), as added Acts 77th Leg., R.S., Ch. 550.)

3 Source Law

4 (h) This section does not apply to a group model
5 health maintenance organization, as defined by Section
6 6A of this Act.

7 Revised Law

8 Sec. 1272.152. GENERAL RESERVE REQUIREMENTS. (a) A
9 delegated network shall maintain reserves adequate for the
10 liabilities and risks assumed by the network, as computed in
11 accordance with accepted standards, practices, and procedures
12 relating to the liabilities and risks for which the reserves are
13 maintained, including known and unknown components and anticipated
14 expenses of providing benefits or services.

15 (b) Except as provided by Sections 1272.153 and 1272.154, a
16 delegated network shall maintain reserves as described by
17 Subsection (c) only with respect to the portion of services assumed
18 under the delegation agreement that is outside the scope of the
19 network's license for medical care or hospital or other
20 institutional services, as applicable.

21 (c) A delegated network shall maintain financial reserves
22 equal to the greater of:

23 (1) 80 percent of the amount of liabilities and risks
24 for which reserves must be maintained under this subchapter and
25 that have been incurred but not paid by the network; or

26 (2) an amount equal to two months of the premium amount
27 assumed by the network for services with respect to which reserves
28 must be maintained under this subchapter. (V.T.I.C. Art. 20A.18D,
29 Secs. (a), (b), (e), as added Acts 77th Leg., R.S., Ch. 550.)

30 Source Law

31 Art. 20A.18D. (a) A delegated network shall
32 establish and maintain reserves that are adequate for
33 the liabilities and risks assumed by the delegated
34 network, as computed in accordance with accepted
35 standards, practices, and procedures relating to the
36 liabilities and risks reserved for, including known
37 and unknown components and anticipated expenses of
38 providing benefits or services.

39 (b) Except as provided by Subsections (c) and

1 (d), the delegated network shall establish and
2 maintain reserves as described by Subsection (e)(1) or
3 (2) only with respect to the portion of services
4 assumed under the delegation agreement that are not
5 within the scope of the network's license for medical
6 care or hospital or other institutional services, as
7 applicable.

8 (e) A delegated network shall maintain
9 financial reserves equal to the greater of:

10 (1) 80 percent of the risk and liabilities
11 that must be reserved under this section and that have
12 been incurred but not paid by the delegated network; or

13 (2) two months of premium amount assumed
14 by the delegated network for services that must be
15 reserved under this section.

16 Revised Law

17 Sec. 1272.153. RESERVE REQUIREMENTS FOR MEDICAL CARE AND
18 HOSPITAL OR INSTITUTIONAL SERVICES. A delegated network that
19 assumes under a delegation agreement both medical care and hospital
20 or institutional services shall maintain reserves adequate to cover
21 the liabilities and risks associated with medical care or hospital
22 or institutional services, whichever category of services is
23 allocated the largest portion of the premium by the health
24 maintenance organization. (V.T.I.C. Art. 20A.18D, Sec. (c), as
25 added Acts 77th Leg., R.S., Ch. 550.)

26 Source Law

27 (c) If the scope of services assumed under the
28 delegation agreement includes both medical care and
29 hospital or institutional services, the delegated
30 network shall establish and maintain reserves that are
31 adequate to cover the liabilities and risks associated
32 with medical care or with hospital or institutional
33 services, whichever type of services has been
34 allocated the largest portion of the premium by the
35 health maintenance organization.

36 Revised Law

37 Sec. 1272.154. RESERVE REQUIREMENTS FOR PRESCRIPTION
38 DRUGS. A delegated network that assumes financial risk for medical
39 care or hospital or institutional services and for prescription
40 drugs, as defined by Section 551.003, Occupations Code, shall
41 maintain, in addition to any other reserves required under this
42 subchapter, reserves adequate to cover the liabilities and risks
43 associated with the prescription drug benefits. (V.T.I.C. Art.
44 20A.18D, Sec. (d), as added Acts 77th Leg., R.S., Ch. 550.)

1 Source Law

2 (d) If the delegated network assumes financial
3 risk for medical care or hospital or institutional
4 services and for prescription drugs, as defined by
5 Section 551.003, Occupations Code, the network shall
6 establish and maintain reserves that are adequate to
7 cover the liabilities and risks associated with the
8 prescription drug benefits, in addition to any other
9 reserves required under this section.

10 Revised Law

11 Sec. 1272.155. FORM OF RESERVES. The reserves required
12 under this subchapter must be:

13 (1) secured by and consist only of United States legal
14 tender or bonds of the United States or this state;

15 (2) held at a financial institution in this state that
16 is chartered by the United States or this state; and

17 (3) held in trust for, for the benefit of, or to
18 provide health care services to enrollees under the delegation
19 agreement. (V.T.I.C. Art. 20A.18D, Sec. (f), as added Acts 77th
20 Leg., R.S., Ch. 550.)

21 Source Law

22 (f) The reserves required under this section
23 must be secured by and only consist of legal tender of
24 the United States or bonds of the United States or this
25 state. The reserves must be held at a financial
26 institution in this state that is chartered by the
27 United States or this state. The reserves must be held
28 in trust for, for the benefit of, or to provide health
29 care services to, enrollees of the health maintenance
30 organization under the agreement between the health
31 maintenance organization and the delegated network.

32 Revised Law

33 Sec. 1272.156. ESCROW ACCOUNT. (a) A delegated network
34 required to maintain reserves under this subchapter shall establish
35 an escrow account to pay claims and deposit the reserves into the
36 escrow account on:

37 (1) notification of the network's intent to terminate
38 or refuse to renew a contract under which the network assumed
39 liabilities and risks from a health maintenance organization; or

40 (2) modification of a contract under which the network
41 assumed liabilities and risks from a health maintenance
42 organization if the modified contract eliminates those liabilities

1 and risks.

2 (b) The delegated network shall notify the commissioner on
3 establishing an escrow account under this section.

4 (c) On the 271st day after the date the reserves are
5 deposited into the escrow account, the delegated network is
6 entitled to the release of funds remaining in escrow. Funds
7 released from the escrow account shall be distributed to each
8 individual who contributed to the reserves deposited into the
9 account in proportion to the individual's total contribution.

10 (d) The commissioner shall take any action necessary to
11 ensure the release of funds remaining in escrow after the date
12 specified by Subsection (c). (V.T.I.C. Art. 20A.18D, Sec. (g), as
13 added Acts 77th Leg., R.S., Ch. 550.)

14 Source Law

15 (g)(1) A delegated network required to
16 establish and maintain reserves under this section
17 shall establish an escrow account for the payment of
18 claims and deposit such reserves into the escrow
19 account upon providing notice of its intent to
20 terminate or non-renew a contract through which the
21 delegated network assumed liabilities and risks from a
22 health maintenance organization. Upon the
23 establishment of the escrow account, the delegated
24 network shall notify the commissioner.

25 (2) A delegated network required to
26 establish and maintain reserves under this section
27 shall establish an escrow account for the payment of
28 claims and deposit such reserves into the escrow
29 account upon the modification of a contract through
30 which the delegated network assumed liabilities and
31 risks from a health maintenance organization if the
32 modified contract eliminates the liabilities and risks
33 previously assumed by the delegated network. Upon the
34 establishment of the escrow account, the delegated
35 network shall notify the commissioner.

36 (3) Two hundred seventy days after the
37 date the reserves are deposited into the escrow
38 account, the delegated network shall be entitled to
39 the release of the remaining amounts held in escrow.

40 (4) The amounts released from the escrow
41 account shall be distributed to those individuals who
42 contributed to the reserves deposited into escrow in
43 proportion to the individuals' total contribution.

44 (5) The commissioner shall, and has the
45 authority to, take any action necessary to ensure the
46 release of any amounts remaining in escrow in excess of
47 the 270-day time period in Subsection (g)(3).

48 Revisor's Note

49 Section (g)(5), V.T.I.C. Article 20A.18D, as
50 added by Chapter 550, Acts of the 77th Legislature,

1 Regular Session, 2001, states that the commissioner
2 shall, "and has the authority to," take certain
3 actions. The revised law omits the quoted language as
4 unnecessary because the requirement that the
5 commissioner perform an action is sufficient to confer
6 on the commissioner the authority to perform the
7 action.

8 [Sections 1272.157-1272.200 reserved for expansion]

9 SUBCHAPTER E. COMPLIANCE

10 Revised Law

11 Sec. 1272.201. APPLICABILITY OF SUBCHAPTER. This
12 subchapter does not apply to a group model health maintenance
13 organization, as defined by Section 843.111. (V.T.I.C. Art.
14 20A.18C, Sec. (q).)

15 Source Law

16 (q) This section does not apply to a group model
17 health maintenance organization, as defined by Section
18 6A of this Act.

19 Revised Law

20 Sec. 1272.202. NOTICE OF NONCOMPLIANCE OR HAZARDOUS
21 OPERATING CONDITION. (a) If a health maintenance organization
22 becomes aware of information that indicates a delegated entity with
23 which the health maintenance organization has entered into a
24 delegation agreement is not operating in accordance with the
25 agreement or is operating in a condition that renders continuing
26 the entity's business hazardous to the enrollees, the health
27 maintenance organization shall in writing:

28 (1) notify the entity of those findings; and

29 (2) request a written explanation and documentation
30 supporting that explanation of the entity's apparent noncompliance
31 or the existence of the hazardous condition.

32 (b) A health maintenance organization shall provide to the
33 commissioner a copy of each notice and request submitted to a
34 delegated entity under this section and each response or other
35 documentation the health maintenance organization receives or

1 generates in response to the notice and request. (V.T.I.C. Art.
2 20A.18C, Sec. (d).)

3 Source Law

4 (d) A health maintenance organization that
5 becomes aware of any information that indicates the
6 delegated entity is not operating in accordance with
7 its written agreement or is operating in a condition
8 that renders the continuance of its business hazardous
9 to the enrollees, shall:

10 (1) notify the delegated entity in writing
11 of those findings;

12 (2) request, in writing, a written
13 explanation, with documentation supporting the
14 explanation, of:

15 (A) the delegated entity's apparent
16 noncompliance with the written agreement; or

17 (B) the existence of the condition
18 that apparently renders the continuance of the
19 delegated entity's business hazardous to the
20 enrollees; and

21 (3) provide the commissioner with copies
22 of all notices and requests submitted to the delegated
23 entity and the responses and other documentation the
24 health maintenance organization generates or receives
25 in response to the notices and requests.

26 Revised Law

27 Sec. 1272.203. RESPONSE TO NOTICE. A delegated entity
28 shall respond in writing to a request from a health maintenance
29 organization under Section 1272.202 not later than the 30th day
30 after the date the entity receives the request. (V.T.I.C. Art.
31 20A.18C, Sec. (e).)

32 Source Law

33 (e) A delegated entity shall respond to a
34 request from a health maintenance organization under
35 Subsection (d) of this section in writing not later
36 than the 30th day after the date the request is
37 received.

38 Revised Law

39 Sec. 1272.204. COOPERATION OF HEALTH MAINTENANCE
40 ORGANIZATION. A health maintenance organization shall cooperate
41 with a delegated entity to correct a failure by the entity to comply
42 with the department's regulatory requirements relating to:

43 (1) a function delegated to the entity by the health
44 maintenance organization; or

45 (2) a matter necessary for the health maintenance
46 organization to ensure compliance with each statutory or regulatory

1 requirement. (V.T.I.C. Art. 20A.18C, Sec. (f).)

2 Source Law

3 (f) The health maintenance organization shall
4 cooperate with the delegated entity to correct any
5 failure by the delegated entity to comply with the
6 regulatory requirements of the department relating to
7 any matters:

8 (1) delegated to the delegated entity by
9 the health maintenance organization; or

10 (2) necessary for the health maintenance
11 organization to ensure compliance with statutory or
12 regulatory requirements.

13 Revised Law

14 Sec. 1272.205. EXAMINATION BY DEPARTMENT; REPORT. (a) On
15 receipt of a notice under Section 1272.202 or if complaints are
16 filed with the department, the department may conduct an
17 examination regarding:

18 (1) any matter contained in the notice; and

19 (2) any other matter relating to the financial
20 solvency of the delegated entity or the entity's ability to meet the
21 entity's responsibilities in connection with a function delegated
22 to the entity by the health maintenance organization.

23 (b) Except as provided by Subsection (c), the department, on
24 completion of an examination under this section, shall report to
25 the delegated entity and the health maintenance organization:

26 (1) the results of the examination; and

27 (2) any action the department determines is necessary
28 to ensure that:

29 (A) the health maintenance organization meets
30 the health maintenance organization's responsibilities under this
31 code, any other insurance laws of this state, and rules adopted by
32 the commissioner; and

33 (B) the entity is able to meet the entity's
34 responsibilities in connection with a function delegated to the
35 entity by the health maintenance organization.

36 (c) The department may not report to the health maintenance
37 organization information relating to fee schedules, prices, or cost
38 of care or other information not relevant to the monitoring plan.

1 (V.T.I.C. Art. 20A.18C, Secs. (g), (h).)

2 Source Law

3 (g) On receipt of a notice under Subsection (d)
4 of this section, or if complaints are filed with the
5 Texas Department of Insurance, the department may
6 examine the matters contained in the notice as well as
7 any other matter relating to the financial solvency of
8 the delegated entity or the delegated entity's ability
9 to meet its responsibilities in connection with any
10 function delegated to the entity by the health
11 maintenance organization.

12 (h) Except as provided by this subsection, the
13 Texas Department of Insurance, on completion of the
14 department's examination, shall report to the
15 delegated entity and the health maintenance
16 organization the results of the department's
17 examination and any action the department determines
18 is necessary to ensure that the health maintenance
19 organization meets its responsibilities under this
20 Act, the Insurance Code, any other insurance laws of
21 this state, and rules adopted by the commissioner, and
22 that the delegated entity can meet its
23 responsibilities in connection with any function
24 delegated to the entity by the health maintenance
25 organization. The department may not report to the
26 health maintenance organization any information
27 regarding fee schedules, prices, cost of care, or
28 other information not relevant to the monitoring plan.

29 Revised Law

30 Sec. 1272.206. RESPONSE TO DEPARTMENT REPORT; CORRECTIVE
31 PLAN. The delegated entity and health maintenance organization
32 shall respond to the department's report under Section 1272.205(b)
33 and submit a corrective plan to the department not later than the
34 30th day after the date of receipt of the report. (V.T.I.C. Art.
35 20A.18C, Sec. (i).)

36 Source Law

37 (i) The delegated entity and the health
38 maintenance organization shall respond to the
39 department's report and submit a corrective plan to the
40 Texas Department of Insurance not later than the 30th
41 day after the date of receipt of the department's
42 report.

43 Revised Law

44 Sec. 1272.207. REQUEST FOR CORRECTIVE ACTION. The
45 department may request at any time that a delegated entity take
46 corrective action to comply with the department's statutory and
47 regulatory requirements that:

48 (1) relate to a function delegated by the health
49 maintenance organization to the entity; or

1 (2) are necessary to ensure the health maintenance
2 organization's compliance with each statutory or regulatory
3 requirement. (V.T.I.C. Art. 20A.18C, Sec. (k).)

4 Source Law

5 (k) The department may request at any time that
6 a delegated entity take corrective action to comply
7 with the department's statutory and regulatory
8 requirements that:

9 (1) relate to any matters delegated by the
10 health maintenance organization to the delegated
11 entity; or

12 (2) are necessary to ensure the health
13 maintenance organization's compliance with statutory
14 and regulatory requirements.

15 Revised Law

16 Sec. 1272.208. AUTHORITY OF COMMISSIONER TO ISSUE
17 ORDER. (a) Regardless of whether a delegated entity complies
18 with a request for corrective action under Section 1272.207, the
19 commissioner may order a health maintenance organization with which
20 the entity has entered into a delegation agreement to take any
21 action the commissioner determines is necessary to ensure that the
22 health maintenance organization is complying with this chapter,
23 Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452.

24 (b) Actions the commissioner may order a health maintenance
25 organization to take under this section include:

26 (1) reassuming the functions delegated to the
27 delegated entity, including claims payments for services
28 previously provided to enrollees;

29 (2) temporarily or permanently ceasing assignment of
30 new enrollees to the entity;

31 (3) temporarily or permanently transferring enrollees
32 to alternative delivery systems to receive services; or

33 (4) terminating the delegation agreement with the
34 entity. (V.T.I.C. Art. 20A.18C, Sec. (l).)

35 Source Law

36 (l) Regardless of whether a delegated entity
37 complies with a request for corrective action, the
38 commissioner may order the health maintenance
39 organization to take any action the commissioner
40 determines is necessary to ensure that the health
41 maintenance organization is in compliance with this

1 Act, including:

2 (1) reassuming the functions delegated to
3 the delegated entity, including claims payments for
4 services previously rendered to enrollees of the
5 health maintenance organization;

6 (2) temporarily or permanently ceasing
7 assignment of new enrollees to the delegated entity;

8 (3) temporarily or permanently
9 transferring enrollees to alternative delivery
10 systems to receive services; or

11 (4) terminating the health maintenance
12 organization's contract with the delegated entity.

13 Revised Law

14 Sec. 1272.209. PUBLIC DOCUMENTS. (a) Except as provided
15 by Subsection (b), a report required under Section 1272.205(b) or
16 corrective plan required under Section 1272.206 is a public
17 document.

18 (b) Health care provider fee schedules, prices, costs of
19 care, or other information that is not relevant to the monitoring
20 plan or is confidential by law is not a public document under this
21 section. (V.T.I.C. Art. 20A.18C, Sec. (j).)

22 Source Law

23 (j) Reports and corrective plans required under
24 Subsection (h) or (i) of this section shall be treated
25 as public documents, except that health care provider
26 fee schedules, prices, costs of care, or other
27 information not relevant to the monitoring plan and
28 any other information that is considered confidential
29 by law shall be considered confidential.

30 Revised Law

31 Sec. 1272.210. RECORD OF COMPLAINTS; REPORT. (a) The
32 department shall:

33 (1) maintain enrollee and provider complaints in a
34 manner that identifies complaints made about limited provider
35 networks and delegated entities; and

36 (2) periodically issue a report on the complaints that
37 includes a list of complaints organized by:

38 (A) category;

39 (B) action taken on the complaint; and

40 (C) entity or network name and type.

41 (b) The department shall make available to the public the
42 report and information to assist the public in evaluating the
43 information contained in the report. (V.T.I.C. Art. 20A.18C, Sec.

1 (m).)

2 Source Law

3 (m) The Texas Department of Insurance shall
4 maintain enrollee and provider complaints in a manner
5 that identifies complaints made about limited provider
6 networks and delegated entities. The department shall
7 periodically issue a report on the complaints received
8 by the department that includes a list of complaints by
9 category, by action taken on the complaint, and by
10 entity or network name and type. The department shall
11 make the report available to the public and shall
12 include information to assist the public in evaluating
13 the information contained in the report.

14 Revised Law

15 Sec. 1272.211. RULES. The commissioner may adopt rules as
16 necessary to implement this subchapter. (V.T.I.C. Art. 20A.18C,
17 Sec. (r).)

18 Source Law

19 (r) The commissioner may adopt rules as
20 necessary to implement this section.

21 [Sections 1272.212-1272.250 reserved for expansion]

22 SUBCHAPTER F. PENALTIES

23 Revised Law

24 Sec. 1272.251. APPLICABILITY OF SUBCHAPTER. This
25 subchapter does not apply to a group model health maintenance
26 organization, as defined by Section 843.111. (V.T.I.C. Art.
27 20A.18C, Sec. (q).)

28 Source Law

29 (q) This section does not apply to a group model
30 health maintenance organization, as defined by Section
31 6A of this Act.

32 Revised Law

33 Sec. 1272.252. SUSPENSION OR REVOCATION OF LICENSE OF
34 THIRD-PARTY ADMINISTRATOR OR UTILIZATION REVIEW AGENT.
35 Notwithstanding any other provision of this code or another
36 insurance law of this state, the commissioner may suspend or revoke
37 the license of a third-party administrator or utilization review
38 agent that fails to comply with Subchapter B, C, or E. (V.T.I.C.
39 Art. 20A.18C, Sec. (n).)

1 Source Law

2 (n) Notwithstanding any other provision of this
3 Act, the Insurance Code, or any other insurance law of
4 this state, the commissioner may suspend or revoke the
5 license of any third party administrator or
6 utilization review agent that fails to comply with
7 this section.

8 Revised Law

9 Sec. 1272.253. SANCTIONS AND PENALTIES AGAINST HEALTH
10 MAINTENANCE ORGANIZATION. The commissioner may impose sanctions
11 or penalties under Chapters 82, 83, and 84 on a health maintenance
12 organization that does not provide in a timely manner information
13 required by Subchapter C. (V.T.I.C. Art. 20A.18C, Sec. (o).)

14 Source Law

15 (o) The commissioner may impose sanctions or
16 penalties under Chapters 82, 83, and 84, Insurance
17 Code, against a health maintenance organization that
18 does not provide timely information required by
19 Subsections (b) and (c) of this section.

20 Revised Law

21 Sec. 1272.254. CONTRACTUAL PENALTIES REQUIRED. A health
22 maintenance organization by contract shall establish penalties for
23 a delegated entity that does not provide in a timely manner
24 information required under a monitoring plan established under
25 Section 1272.053. (V.T.I.C. Art. 20A.18C, Sec. (p).)

26 Source Law

27 (p) A health maintenance organization shall by
28 contract establish penalties for delegated entities
29 that do not provide timely information required under
30 a monitoring plan as required by Subsection (a)(1) of
31 this section.

32 Revised Law

33 Sec. 1272.255. RULES. The commissioner may adopt rules as
34 necessary to implement this subchapter. (V.T.I.C. Art. 20A.18C,
35 Sec. (r).)

36 Source Law

37 (r) The commissioner may adopt rules as
38 necessary to implement this section.

39 [Sections 1272.256-1272.300 reserved for expansion]

1 SUBCHAPTER G. PROVISION OF SERVICES BY LIMITED PROVIDER
2 NETWORK OR DELEGATED ENTITY

3 Revised Law

4 Sec. 1272.301. ACCESS TO OUT-OF-NETWORK SERVICES. (a) A
5 contract between a health maintenance organization and a limited
6 provider network or delegated entity must provide that:

7 (1) if medically necessary covered services are not
8 available through network physicians or providers, the limited
9 provider network or delegated entity, on the request of a network
10 physician or provider, shall:

11 (A) allow a referral to a non-network physician
12 or provider; and

13 (B) fully reimburse the non-network physician or
14 provider at the usual and customary rate or an agreed rate; and

15 (2) before the limited provider network or delegated
16 entity may deny a referral to a non-network physician or provider, a
17 specialist of the same or similar specialty as the type of physician
18 or provider to whom the referral is requested must conduct a review
19 of the request.

20 (b) The limited provider network or delegated entity shall
21 allow the referral within the time appropriate to the circumstances
22 relating to the delivery of the services and the condition of the
23 enrollee who is a patient, but not later than the fifth business day
24 after the date the network or entity receives any reasonably
25 requested documentation.

26 (c) An enrollee may not be required to change the enrollee's
27 primary care physician or specialist providers to receive medically
28 necessary covered services that are not available within the
29 limited provider network or through the delegated entity.

30 (d) A denial of out-of-network services under this section
31 is subject to appeal under Article 21.58A. (V.T.I.C. Art.
32 20A.18F.)

33 Source Law

34 Art. 20A.18F. (a) Each contract between a

1 health maintenance organization and a limited provider
2 network or delegated entity must provide that if
3 medically necessary covered services are not available
4 through network physicians or providers, the limited
5 provider network or delegated entity must, on request
6 of a network physician or provider, allow a referral to
7 a non-network physician or provider and shall fully
8 reimburse the non-network provider at the usual and
9 customary or an agreed-upon rate.

10 (b) The referral shall be allowed within the
11 time appropriate to the circumstances relating to the
12 delivery of the services and the condition of the
13 patient, but not later than the fifth business day
14 after the date any reasonably requested documentation
15 is received by the limited provider network or
16 delegated entity.

17 (c) The enrollee may not be required to change
18 the enrollee's primary care physician or specialist
19 providers to receive medically necessary covered
20 services that are not available within the limited
21 provider network or delegated entity.

22 (d) Each contract must also provide for a review
23 by a specialist of the same or similar specialty as the
24 type of physician or provider to whom a referral is
25 requested before the limited provider network or
26 delegated entity may deny a referral.

27 (e) A denial of out-of-network services under
28 this section is subject to appeal under Article
29 21.58A, Insurance Code.

30 Revisor's Note

31 (1) Section (a), V.T.I.C. Article 20A.18F,
32 states that under certain circumstances a limited
33 provider network must allow a referral to a
34 non-network "physician or provider" and fully
35 reimburse the non-network "provider." It is clear
36 from the context of Article 20A.18F that the
37 reimbursement is to be made to the person to whom the
38 referral is made, whether a physician or provider. The
39 revised law is drafted accordingly.

40 (2) Section (b), V.T.I.C. Article 20A.18F,
41 refers to the condition of the "patient." The revised
42 law substitutes "enrollee who is a patient" for
43 "patient" for accuracy and consistency of terminology
44 throughout this section. Similar changes have been
45 made throughout this subchapter.

46 Revised Law

47 Sec. 1272.302. CONTINUITY OF CARE. (a) In this section,
48 "special circumstance" means a condition regarding which a treating

1 physician or provider reasonably believes that discontinuing care
2 by that physician or provider could cause harm to an enrollee who is
3 a patient. Examples of an enrollee who has a special circumstance
4 include an enrollee with a disability, acute condition, or
5 life-threatening illness and an enrollee who is past the 24th week
6 of pregnancy.

7 (b) A contract between a health maintenance organization
8 and a limited provider network or delegated entity must require
9 that each contract between the network or entity and a physician or
10 provider must:

11 (1) require that reasonable advance notice be given to
12 an enrollee of an impending termination from the network or entity
13 of a physician or provider who is currently treating the enrollee;
14 and

15 (2) provide that the termination of the physician's or
16 provider's contract, except for reason of medical competence or
17 professional behavior, does not release the network or entity from
18 the obligation to reimburse the physician or provider for treatment
19 of an enrollee who has a special circumstance at a rate that is not
20 less than the contract rate for that enrollee's care in exchange for
21 continuity of ongoing treatment of the enrollee then receiving
22 medically necessary treatment in accordance with the dictates of
23 medical prudence.

24 (c) The treating physician or provider shall identify a
25 special circumstance. That physician or provider must:

26 (1) request that the enrollee be permitted to continue
27 treatment under the physician's or provider's care; and

28 (2) agree not to seek payment from the enrollee who is
29 a patient of any amount for which the enrollee would not be
30 responsible if the physician or provider continued to be included
31 in the limited provider network or delegated entity.

32 (d) Except as provided by Subsection (e), this section does
33 not extend the obligation of a limited provider network or
34 delegated entity to reimburse a terminated physician or provider

1 for ongoing treatment of an enrollee after:

2 (1) the 90th day after the effective date of the
3 termination; or

4 (2) if the enrollee has been diagnosed with a terminal
5 illness at the time of termination, the expiration of the
6 nine-month period after the effective date of the termination.

7 (e) If an enrollee is past the 24th week of pregnancy at the
8 time of termination, the obligation of the limited provider network
9 or delegated entity to reimburse the terminated physician or
10 provider or, if applicable, the enrollee extends through delivery
11 of the child, immediate postpartum care, and a follow-up checkup
12 within the six-week period after delivery.

13 (f) A contract between a limited provider network or
14 delegated entity and a physician or provider must provide
15 procedures for resolving disputes regarding the necessity for
16 continued treatment by a physician or provider. (V.T.I.C. Art.
17 20A.18E.)

18 Source Law

19 Art. 20A.18E. (a) In this section, "special
20 circumstance" means a condition for which the treating
21 physician or provider reasonably believes that
22 discontinuing care by the treating physician or
23 provider could cause harm to the patient.

24 (b) Each contract between a health maintenance
25 organization and a limited provider network or
26 delegated entity must require that each contract
27 between the network or entity and a physician or
28 provider provide that:

29 (1) reasonable advance notice be given to
30 an enrollee of the impending termination from the
31 limited provider network or delegated entity of a
32 physician or provider who is currently treating the
33 enrollee; and

34 (2) the termination of the physician or
35 provider contract, except for reason of medical
36 competence or professional behavior, does not release
37 the limited provider network or delegated entity from
38 the obligation to reimburse a physician or provider
39 who is treating an enrollee of special circumstance,
40 such as a person who has a disability, acute condition,
41 or life-threatening illness or is past the 24th week of
42 pregnancy, at a rate that is not less than the contract
43 rate for that enrollee's care in exchange for
44 continuity of ongoing treatment of an enrollee then
45 receiving medically necessary treatment in accordance
46 with the dictates of medical prudence.

47 (c) A special circumstance shall be identified
48 by the treating physician or provider, who must
49 request that the enrollee be permitted to continue

1 treatment under the physician's or provider's care and
2 agree not to seek payment from the patient of any
3 amounts for which the enrollee would not be
4 responsible if the physician or provider were still in
5 the limited provider network or delegated entity.

6 (d) Contracts between a limited provider
7 network or delegated entity and physicians or
8 providers shall provide procedures for resolving
9 disputes regarding the necessity for continued
10 treatment by a physician or provider.

11 (e) This section does not extend the obligation
12 of a limited provider network or delegated entity to
13 reimburse a terminated physician or provider for
14 ongoing treatment of an enrollee beyond the 90th day
15 after the effective date of the termination, or beyond
16 nine months in the case of an enrollee who at the time
17 of the termination has been diagnosed with a terminal
18 illness. However, the obligation of the limited
19 provider network or delegated entity to reimburse the
20 terminated physician or provider or, if applicable,
21 the enrollee for services to an enrollee who at the
22 time of the termination is past the 24th week of
23 pregnancy, extends through delivery of the child,
24 immediate postpartum care, and the follow-up checkup
25 within the first six weeks of delivery.

26 CHAPTER 1273. POINT-OF-SERVICE PLANS

27 SUBCHAPTER A. BLENDED CONTRACTS

28 Sec. 1273.001. DEFINITIONS 835
29 Sec. 1273.002. POINT-OF-SERVICE PLAN. 836
30 Sec. 1273.003. BLENDED CONTRACT. 836
31 Sec. 1273.004. LIMITED BENEFITS AND SERVICES;
32 COST-SHARING PROVISIONS 837
33 Sec. 1273.005. RULES 838

34 [Sections 1273.006-1273.050 reserved for expansion]

35 SUBCHAPTER B. AVAILABILITY OF HEALTH BENEFIT COVERAGE OPTIONS

36 Sec. 1273.051. DEFINITIONS 838
37 Sec. 1273.052. OFFER OF COVERAGE THROUGH NON-NETWORK PLAN
38 REQUIRED 841
39 Sec. 1273.053. COVERAGE OPTIONS. 842
40 Sec. 1273.054. PREMIUM FOR COVERAGE OPTIONS 842
41 Sec. 1273.055. COST-SHARING PROVISIONS 843
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43 Sec. 1273.057. RULES 844

1 CHAPTER 1273. POINT-OF-SERVICE PLANS

2 SUBCHAPTER A. BLENDED CONTRACTS

3 Revised Law

4 Sec. 1273.001. DEFINITIONS. In this subchapter:

5 (1) "Blended contract" means a single document,
6 including a single contract policy, certificate, or evidence of
7 coverage, that provides a combination of indemnity and health
8 maintenance organization benefits.

9 (2) "Health maintenance organization" has the meaning
10 assigned by Section 843.002.

11 (3) "Insurer" means an insurance company,
12 association, or organization authorized to engage in business in
13 this state under Chapter 841, 842, 861, 881, 882, 883, 884, 885,
14 886, 887, 888, 941, 942, or 982.

15 (4) "Point-of-service plan" means an arrangement
16 under which:

17 (A) an enrollee chooses to obtain benefits or
18 services through:

19 (i) a health maintenance organization
20 delivery network, including a limited provider network; or

21 (ii) a non-network delivery system outside
22 the health maintenance organization delivery network, including a
23 limited provider network, that is administered under an indemnity
24 benefit arrangement for the cost of health care services; or

25 (B) indemnity benefits for the cost of health
26 care services are provided by an insurer or group hospital service
27 corporation in conjunction with network benefits arranged or
28 provided by a health maintenance organization. (V.T.I.C. Art.
29 3.64, Sec. (a).)

30 Source Law

31 Art. 3.64. (a) In this article:

32 (1) "Blended contract" means a single
33 document, including a single contract policy,
34 certificate, or evidence of coverage, that provides a
35 combination of indemnity and health maintenance
36 organization benefits.

37 (2) "Health maintenance organization" has

1 the meaning assigned by Section 2, Texas Health
2 Maintenance Organization Act (Article 20A.02, Vernon's
3 Texas Insurance Code).

4 (3) "Insurance carrier" means an insurance
5 company, group hospital service corporation,
6 association, or organization authorized to do business
7 in this state under this chapter or Chapter 8, 10, 11,
8 12, 13, 14, 15, 18, 19, 20, or 22 of this code.

9 (4) "Point-of-service plan" means an
10 arrangement under which:

11 (A) an enrollee may choose to obtain
12 benefits or services, or both benefits and services,
13 through either a health maintenance organization
14 delivery network, including a limited provider
15 network, or through a non-network delivery system
16 outside the health maintenance organization's health
17 care delivery network, including a limited provider
18 network, and that are administered through an
19 indemnity benefit arrangement for the cost of health
20 care services; or

21 (B) indemnity benefits for the cost
22 of the health care services may be provided by an
23 insurer or group hospital service corporation in
24 conjunction with network benefits arranged or provided
25 by a health maintenance organization.

26 Revisor's Note

27 Section (a)(3), V.T.I.C. Article 3.64, refers to
28 Chapter 3 of the Insurance Code. The relevant portions
29 of Chapter 3, relating to authorization of domestic,
30 foreign, and alien life, health, and accident
31 insurance companies, are revised in Chapters 841 and
32 982 of this code. The revised law is drafted
33 accordingly.

34 Revised Law

35 Sec. 1273.002. POINT-OF-SERVICE PLAN. An insurer may
36 contract with a health maintenance organization to provide benefits
37 under a point-of-service plan, including optional coverage for
38 out-of-area services or out-of-network care. (V.T.I.C. Art. 3.64,
39 Sec. (b).)

40 Source Law

41 (b) An insurance carrier may contract with a
42 health maintenance organization to provide benefits
43 under a point-of-service plan, including optional
44 coverage for out-of-area services or out-of-network
45 care.

46 Revised Law

47 Sec. 1273.003. BLENDED CONTRACT. (a) A health maintenance
48 organization and an insurer may offer a blended contract. The use

1 of a blended contract is limited to point-of-service arrangements
2 between a health maintenance organization and an insurer.

3 (b) A blended contract delivered, issued, or used in this
4 state is subject to, and must be filed with the department for
5 approval as provided by, Chapter 1701 and Section 1271.101.
6 (V.T.I.C. Art. 3.64, Secs. (c), (d).)

7 Source Law

8 (c) An insurance carrier and a health
9 maintenance organization may offer a blended contract
10 if indemnity benefits are combined with health
11 maintenance organization benefits. The use of a
12 blended contract is limited to point-of-service
13 arrangements between an insurance carrier and a health
14 maintenance organization.

15 (d) A blended contract delivered, issued, or
16 used in this state is subject to and must be filed with
17 the department for approval as provided by Article
18 3.42 of this code and Section 9(a)(5), Texas Health
19 Maintenance Organization Act (Article 20A.09, Vernon's
20 Texas Insurance Code).

21 Revisor's Note

22 Section (c), V.T.I.C. Article 3.64, provides in
23 part that an insurer and a health maintenance
24 organization may offer a blended contract "if
25 indemnity benefits are combined with health
26 maintenance organization benefits." The revised law
27 omits the quoted language as unnecessary because
28 "blended contract" is defined by Section (a)(1),
29 Article 3.64, which is revised as Section 1273.001(1),
30 as a document that "provides a combination of
31 indemnity and health maintenance organization
32 benefits."

33 Revised Law

34 Sec. 1273.004. LIMITED BENEFITS AND SERVICES; COST-SHARING
35 PROVISIONS. Indemnity benefits and services provided under a
36 point-of-service plan may be limited to those services described by
37 the blended contract and may be subject to different cost-sharing
38 provisions. The cost-sharing provisions for indemnity benefits may
39 be higher than the cost-sharing provisions for in-network health
40 maintenance organization coverage. For an enrollee in a limited

1 provider network, higher cost-sharing may be imposed only when the
2 enrollee obtains benefits or services outside the health
3 maintenance organization delivery network. (V.T.I.C. Art. 3.64,
4 Sec. (e).)

5 Source Law

6 (e) Indemnity benefits and services provided
7 under a point-of-service plan may be limited to those
8 services as defined by the blended contract and may be
9 subject to different cost-sharing provisions. The
10 cost-sharing provisions for the indemnity benefits may
11 be higher than cost-sharing provisions for in-network
12 health maintenance organization coverage. For
13 enrollees in limited provider networks, higher cost
14 sharing may be imposed only when obtaining benefits or
15 services outside the health maintenance organization
16 delivery network.

17 Revised Law

18 Sec. 1273.005. RULES. The commissioner may adopt rules to
19 implement this subchapter. (V.T.I.C. Art. 3.64, Sec. (f).)

20 Source Law

21 (f) The commissioner may adopt rules to
22 implement this article.

23 [Sections 1273.006-1273.050 reserved for expansion]

24 SUBCHAPTER B. AVAILABILITY OF HEALTH BENEFIT COVERAGE

25 OPTIONS

26 Revised Law

27 Sec. 1273.051. DEFINITIONS. In this subchapter:

28 (1) "Employee" means an individual employed by an
29 employer.

30 (2) "Health benefit plan" has the meaning assigned by
31 Section 1501.002.

32 (3) "Non-network plan" means health benefit coverage
33 that provides an enrollee an opportunity to obtain health care
34 services through a health delivery system other than a health
35 maintenance organization delivery network, as defined by Section
36 843.002.

37 (4) "Point-of-service plan" means an arrangement
38 under which an enrollee chooses to obtain benefits or services
39 through:

1 (A) a health maintenance organization delivery
2 network, including a limited provider network; or

3 (B) a non-network delivery system outside the
4 health maintenance organization delivery network, including a
5 limited provider network, that is administered under an indemnity
6 benefit arrangement for the cost of health care services.

7 (5) "Preferred provider benefit plan" means an
8 insurance policy issued under Chapter 1301.

9 (6) "Small employer health benefit plan" has the
10 meaning assigned by Section 1501.002. (V.T.I.C. Art. 26.02,
11 Subdivs. (10), (11), (31), as amended Acts 77th Leg., R.S., Ch. 608,
12 (32), as amended Acts 77th Leg., R.S., Ch. 823; Art. 26.09, Sec.
13 (a).)

14 Source Law

15 Art. 26.02. In this chapter:

16 (10) "Employee" means any individual
17 employed by an employer.

18 (11) "Health benefit plan" means a group,
19 blanket, or franchise insurance policy, a certificate
20 issued under a group policy, a group hospital service
21 contract, or a group subscriber contract or evidence
22 of coverage issued by a health maintenance
23 organization that provides benefits for health care
24 services. The term does not include:

25 (A) accident-only or disability
26 income insurance or a combination of accident-only and
27 disability income insurance;

28 (B) credit-only insurance;

29 (C) disability insurance coverage;

30 (D) coverage for a specified disease
31 or illness;

32 (E) Medicare services under a federal
33 contract;

34 (F) Medicare supplement and Medicare
35 Select policies regulated in accordance with federal
36 law;

37 (G) long-term care coverage or
38 benefits, nursing home care coverage or benefits, home
39 health care coverage or benefits, community-based care
40 coverage or benefits, or any combination of those
41 coverages or benefits;

42 (H) coverage that provides
43 limited-scope dental or vision benefits;

44 (I) coverage provided by a single
45 service health maintenance organization;

46 (J) coverage issued as a supplement
47 to liability insurance;

48 (K) workers' compensation or similar
49 insurance;

50 (L) automobile medical payment
51 insurance coverage;

52 (M) jointly managed trusts

1 authorized under 29 U.S.C. Section 141 et seq. that
2 contain a plan of benefits for employees that is
3 negotiated in a collective bargaining agreement
4 governing wages, hours, and working conditions of the
5 employees that is authorized under 29 U.S.C. Section
6 157;

7 (N) hospital indemnity or other fixed
8 indemnity insurance;

9 (O) reinsurance contracts issued on a
10 stop-loss, quota-share, or similar basis;

11 (P) short-term major medical
12 contracts;

13 (Q) liability insurance, including
14 general liability insurance and automobile liability
15 insurance;

16 (R) other coverage that is:

17 (i) similar to the coverage
18 described by this subdivision under which benefits for
19 medical care are secondary or incidental to other
20 insurance benefits; and

21 (ii) specified in federal
22 regulations;

23 (S) coverage for on-site medical
24 clinics; or

25 (T) coverage that provides other
26 limited benefits specified by federal regulations.

27 (31) "Small employer health benefit plan"
28 means a plan developed by the commissioner under
29 Subchapter E of this chapter or any other health
30 benefit plan offered to a small employer in accordance
31 with Article 26.42(c) or 26.48 of this code.

32 (32) "Small employer health benefit plan"
33 means a plan developed by the commissioner under
34 Subchapter E of this chapter or any other health
35 benefit plan offered to a small employer in accordance
36 with Article 26.42(c) or 26.48 of this code.

37 Art. 26.09. (a) In this article:

38 (1) "Non-network plan" means health
39 benefit coverage that provides an enrollee an
40 opportunity to obtain health care services through a
41 health delivery system other than a health maintenance
42 organization delivery network, as defined by Section
43 2, Texas Health Maintenance Organization Act (Article
44 20A.02, Vernon's Texas Insurance Code).

45 (2) "Point-of-service plan" means an
46 arrangement under which an enrollee may choose to
47 obtain benefits and services, or both benefits and
48 services, through either a health maintenance
49 organization delivery network, including a limited
50 provider network, or through a non-network delivery
51 system outside the health maintenance organization's
52 health care delivery network, including a limited
53 provider network, and that are administered through an
54 indemnity benefit arrangement for the cost of health
55 care services.

56 (3) "Preferred provider benefit plan"
57 means an insurance policy issued and licensed under
58 Article 3.70-3C of this code, as added by Chapter 1024,
59 Acts of the 75th Legislature, Regular Session, 1997.

60 Revisor's Note

61 (1) Subdivision (11), V.T.I.C. Article 26.02,
62 defines "health benefit plan," and Subdivision (31),

1 V.T.I.C. Article 26.02, as amended by Chapter 608,
2 Acts of the 77th Legislature, Regular Session, 2001,
3 and Subdivision (32), V.T.I.C. Article 26.02, as
4 amended by Chapter 823, Acts of the 77th Legislature,
5 Regular Session, 2001, define "small employer health
6 benefit plan." The substance of those definitions is
7 revised in Section 1501.002, and the revised law
8 substitutes a cross-reference to that section for the
9 substance of the definitions.

10 (2) Subsection (a)(3), V.T.I.C. Article 26.09,
11 defines "preferred provider benefit plan" as an
12 insurance policy "issued and licensed" under V.T.I.C.
13 Article 3.70-3C, as added by Chapter 1024, Acts of the
14 75th Legislature, Regular Session, 1997, revised as
15 Chapter 1301. The revised law omits the reference to
16 "licensed" as inaccurate and unnecessary. An
17 insurance policy is not "licensed" under Article
18 3.70-3C, and the requirement that the policy be
19 "issued" under that article is sufficient to ensure
20 that the policy complies with the requirements of that
21 article.

22 Revised Law

23 Sec. 1273.052. OFFER OF COVERAGE THROUGH NON-NETWORK PLAN
24 REQUIRED. (a) Except as provided by Subsection (b), if the only
25 health benefit coverage offered under an employer's health benefit
26 plan is a network-based delivery system of coverage offered by one
27 or more health maintenance organizations, each health maintenance
28 organization offering coverage must offer to all eligible
29 employees, at the time of enrollment and at least annually, the
30 opportunity to obtain coverage through a non-network plan.

31 (b) Each health maintenance organization to which
32 Subsection (a) applies may enter into an agreement designating one
33 or more of those health maintenance organizations to offer the
34 coverage required by Subsection (a) for eligible employees of the

1 employer. (V.T.I.C. Art. 26.09, Sec. (b) (part).)

2 Source Law

3 (b) If the only health benefit coverage offered
4 under an employer's health benefit plan is a
5 network-based delivery system of coverage offered by
6 one or more health maintenance organizations, each
7 health maintenance organization offering coverage
8 under the employer's health benefit plan must offer to
9 all eligible employees the opportunity to obtain
10 health benefit coverage through a non-network plan at
11 the time of enrollment and at least annually, unless
12 all health maintenance organizations offering
13 coverage under the employer's health benefit plan
14 enter into an agreement designating one or more of
15 those health maintenance organizations to offer that
16 coverage. . . .

17 Revised Law

18 Sec. 1273.053. COVERAGE OPTIONS. The coverage required to
19 be offered under this subchapter may be provided through:

- 20 (1) a point-of-service plan;
- 21 (2) a preferred provider benefit plan; or
- 22 (3) any coverage arrangement that provides an enrollee
23 with access to services outside the health maintenance
24 organization's or limited provider network's delivery network.
25 (V.T.I.C. Art. 26.09, Sec. (b) (part).)

26 Source Law

27 (b) . . . The coverage required under this
28 subsection may be provided through a point-of-service
29 contract, a preferred provider benefit plan, or any
30 coverage arrangement that allows an enrollee to access
31 services outside the health maintenance organization's
32 or limited provider network's delivery network.

33 Revisor's Note

34 Section (b), V.T.I.C. Article 26.09, refers to a
35 "point-of-service contract." Throughout this
36 subchapter, the revised law substitutes
37 "point-of-service plan" for "point-of-service
38 contract" because "point-of-service plan" is the term
39 defined under Section (a)(2), V.T.I.C. Article 26.09,
40 revised as Section 1273.051(4).

41 Revised Law

42 Sec. 1273.054. PREMIUM FOR COVERAGE OPTIONS. The premium
43 for coverage required to be offered under this subchapter must be

1 based on the actuarial value of that coverage and may be different
2 from the premium for coverage otherwise offered by the health
3 maintenance organization. (V.T.I.C. Art. 26.09, Sec. (c).)

4 Source Law

5 (c) The premium for coverage required to be
6 offered under this article shall be based on the
7 actuarial value of that coverage and may be different
8 than the premium for the health maintenance
9 organization coverage.

10 Revised Law

11 Sec. 1273.055. COST-SHARING PROVISIONS. (a) Different
12 cost-sharing provisions may be imposed for a point-of-service plan
13 offered under this subchapter, and those provisions may be higher
14 than the cost-sharing provisions for in-network health maintenance
15 organization coverage. For an enrollee in a limited provider
16 network, higher cost-sharing may be imposed only when the enrollee
17 obtains benefits or services outside the health maintenance
18 organization delivery network.

19 (b) An employee who chooses the non-network plan is
20 responsible for any additional costs for the non-network plan, and
21 the employer may impose a reasonable administrative fee for
22 providing the non-network plan. (V.T.I.C. Art. 26.09, Secs. (d),
23 (e).)

24 Source Law

25 (d) Different cost-sharing provisions may be
26 imposed for a point-of-service contract offered under
27 this article and may be higher than cost-sharing
28 provisions for in-network health maintenance
29 organization coverage. For enrollees in limited
30 provider networks, higher cost sharing may be imposed
31 only when obtaining benefits or services outside the
32 health maintenance organization delivery network.

33 (e) Any additional costs for the non-network
34 plan are the responsibility of the employee who
35 chooses the non-network plan, and the employer may
36 impose a reasonable administrative cost for providing
37 the non-network plan option.

38 Revised Law

39 Sec. 1273.056. EXCEPTIONS. This subchapter does not apply
40 to:

- 41 (1) a small employer health benefit plan; or
42 (2) a group model health maintenance organization that

1 is a nonprofit, state-certified health maintenance organization
2 that:

3 (A) provides the majority of its professional
4 services through a single group medical practice that is governed
5 by a board composed entirely of physicians; and

6 (B) educates medical students or resident
7 physicians through a contract with the medical school component of
8 a Texas state-supported college or university accredited by the
9 Accreditation Council on Graduate Medical Education or the American
10 Osteopathic Association. (V.T.I.C. Art. 26.09, Sec. (f).)

11 Source Law

12 (f) This article does not apply to:

13 (1) a small employer health benefit plan;

14 or

15 (2) a group model health maintenance
16 organization that is a nonprofit, state-certified
17 health maintenance organization that provides the
18 majority of its professional services through a single
19 group medical practice that is governed by a board
20 composed entirely of physicians and that educates
21 medical students or resident physicians through a
22 contract with the medical school component of a Texas
23 state-supported college or university accredited by
24 the Accrediting Council on Graduate Medical Education
25 or the American Osteopathic Association.

26 Revisor's Note

27 Section (f)(2), V.T.I.C. Article 26.09, refers
28 to the "Accrediting Council on Graduate Medical
29 Education." The revised law substitutes
30 "Accreditation Council on Graduate Medical Education"
31 because that is the proper name of that organization.

32 Revised Law

33 Sec. 1273.057. RULES. The commissioner shall adopt rules
34 necessary to administer this subchapter. (V.T.I.C. Art. 26.04
35 (part).)

36 Source Law

37 Art. 26.04. The commissioner shall adopt rules
38 as necessary to implement this chapter and

39 [Chapters 1274-1300 reserved for expansion]

1 SUBTITLE D. PREFERRED PROVIDER BENEFIT PLANS

2 CHAPTER 1301. PREFERRED PROVIDER BENEFIT PLANS

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12 [Sections 1301.008-1301.050 reserved for expansion]

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15		SUBCHAPTER A. GENERAL PROVISIONS	
16		<u>Revised Law</u>	
17	Sec. 1301.001.	DEFINITIONS. In this chapter:	
18		(1) "Health care provider" means a practitioner,	
19		institutional provider, or other person or organization that	
20		furnishes health care services and that is licensed or otherwise	
21		authorized to practice in this state. The term does not include a	
22		physician.	
23		(2) "Health insurance policy" means a group or	
24		individual insurance policy, certificate, or contract providing	
25		benefits for medical or surgical expenses incurred as a result of an	
26		accident or sickness.	
27		(3) "Hospital" means a licensed public or private	
28		institution as defined by Chapter 241, Health and Safety Code, or	
29		Subtitle C, Title 7, Health and Safety Code.	
30		(4) "Institutional provider" means a hospital,	
31		nursing home, or other medical or health-related service facility	
32		that provides care for the sick or injured or other care that may be	
33		covered in a health insurance policy.	
34		(5) "Insurer" means a life, health, and accident	

1 insurance company, health and accident insurance company, health
2 insurance company, or other company operating under Chapter 841,
3 842, 884, 885, 982, or 1501, that is authorized to issue, deliver,
4 or issue for delivery in this state health insurance policies.

5 (6) "Physician" means a person licensed to practice
6 medicine in this state.

7 (7) "Practitioner" means a person who practices a
8 healing art and is a practitioner described by Section 1451.001 or
9 1451.101.

10 (8) "Preferred provider" means a physician or health
11 care provider, or an organization of physicians or health care
12 providers, who contracts with an insurer to provide medical care or
13 health care to insureds covered by a health insurance policy.

14 (9) "Preferred provider benefit plan" means a benefit
15 plan in which an insurer provides, through its health insurance
16 policy, for the payment of a level of coverage that is different
17 from the basic level of coverage provided by the health insurance
18 policy if the insured person uses a preferred provider.

19 (10) "Service area" means a geographic area or areas
20 specified in a health insurance policy or preferred provider
21 contract in which a network of preferred providers is offered and
22 available. (V.T.I.C. Art. 3.70-3C, Secs. 1(2), (3), (4), (5), (6),
23 (8), (9), (10), (13), 2 (part), as added Acts 75th Leg., R.S., Ch.
24 1024; Art. 3.70-3C, Sec. 1, as added Acts 75th Leg., R.S., Ch.
25 1260.)

26 Source Law

27 [Art. 3.70-3C, as added Acts 75th Leg., R.S., Ch.
28 1024]

29 (2) "Health insurance policy" means a
30 group or individual insurance policy, certificate, or
31 contract providing benefits for medical or surgical
32 expenses incurred as a result of an accident or
33 sickness.

34 (3) "Health care provider" or "provider"
35 means any practitioner, institutional provider, or
36 other person or organization that furnishes health
37 care services and that is licensed or otherwise
38 authorized to practice in this state, other than a
39 physician.

40 (4) "Hospital" means a licensed public or
41 private institution as defined in Chapter 241, Health

1 and Safety Code, or in Subtitle C, Title 7, Health and
2 Safety Code.

3 (5) "Institutional provider" means a
4 hospital, nursing home, or any other medical or
5 health-related service facility caring for the sick or
6 injured or providing care for other coverage which may
7 be provided in a health insurance policy.

8 (6) "Insurer" means any life, health, and
9 accident; health and accident; or health insurance
10 company or company operating pursuant to Chapter 3,
11 10, 20, 22, or 26 of this code authorized to issue,
12 deliver, or issue for delivery in this state health
13 insurance policies, certificates, or contracts.

14 (8) "Physician" means anyone licensed to
15 practice medicine in the State of Texas.

16 (9) "Practitioner" means a person who
17 practices a healing art and is a practitioner
18 described by:

19 (A) Section 2(B), Chapter 397, Acts
20 of the 54th Legislature, 1955 (Article 3.70-2,
21 Vernon's Texas Insurance Code); or

22 (B) Article 21.52 of this code.

23 (10) "Preferred provider" means a
24 physician, practitioner, hospital, institutional
25 provider, or health care provider, or an organization
26 of physicians or health care providers, who contracts
27 with an insurer to provide medical care or health care
28 to insureds covered by a health insurance policy,
29 certificate, or contract.

30 (13) "Service area" means a geographic
31 area or areas set forth in the health insurance policy
32 or preferred provider contract in which a network of
33 preferred providers is offered and available.

34 Sec. 2. This article applies to any preferred
35 provider benefit plan in which an insurer provides,
36 through its health insurance policy, for the payment
37 of a level of coverage which is different from the
38 basic level of coverage provided by the health
39 insurance policy if the insured uses a preferred
40 provider. . . .

41 Art. 3.70-3C [as added Acts 75th Leg., R.S., Ch.
42 1260]

43 Sec. 1. In this article:

44 (1) "Preferred provider" means a
45 physician, advanced practice nurse, physician
46 assistant, or other health care provider, or an
47 organization of physicians or health care providers,
48 who contracts with an insurer to provide medical care
49 or health care to insureds covered by a health
50 insurance policy, certificate, or contract.

51 (2) "Preferred provider benefit plan"
52 means a benefit plan through which an insurer
53 provides, through its health insurance policy, for the
54 payment of a level of coverage that is different from
55 the basic level of coverage provided by the health
56 insurance policy if the insured uses a preferred
57 provider.

58 Revisor's Note

59 (1) Section 1(6), V.T.I.C. Article 3.70-3C, as
60 added by Chapter 1024, Acts of the 75th Legislature,
61 Regular Session, 1997, refers to Chapter 3 of the

1 Insurance Code. The pertinent portions of Chapter 3,
2 relating to organization of entities that may write
3 health insurance policies, are revised in Chapters 841
4 and 982 of this code. The revised law is drafted
5 accordingly.

6 (2) Section 1(10), V.T.I.C. Article 3.70-3C, as
7 added by Chapter 1024, Acts of the 75th Legislature,
8 Regular Session, 1997, in part defines "preferred
9 provider" as a "physician, practitioner, hospital,
10 institutional provider, or health care provider." The
11 revised law omits the references to "practitioner,"
12 "hospital," and "institutional provider" because each
13 of those entities is explicitly listed or clearly
14 included within the meaning of "health care provider"
15 under Section 1(3) of Article 3.70-3C.

16 (3) Section 1(1), V.T.I.C. Article 3.70-3C, as
17 added by Chapter 1260, Acts of the 75th Legislature,
18 Regular Session, 1997, in part defines "preferred
19 provider" as a "physician, advanced practice nurse,
20 physician assistant, or other health care provider."
21 The revised law omits the references to "advanced
22 practice nurse" and "physician assistant" because each
23 of those entities is a practitioner described by
24 Section 2(B), Chapter 397, Acts of the 54th
25 Legislature, Regular Session, 1955 (Article 3.70-2,
26 Vernon's Texas Insurance Code), revised as Section
27 1451.001 of this code. As such, each of those entities
28 is included within the meaning of "health care
29 provider" under Section 1(3), V.T.I.C. Article
30 3.70-3C, as added by Chapter 1024, Acts of the 75th
31 Legislature, Regular Session, 1997, and the revised
32 law definition of "preferred provider" specifically
33 lists health care providers.

1 Revised Law

2 Sec. 1301.002. NONAPPLICABILITY TO DENTAL CARE
3 BENEFITS. This chapter does not apply to a provision for dental
4 care benefits in a health insurance policy. (V.T.I.C. Art.
5 3.70-3C, Sec. 2 (part), as added Acts 75th Leg., R.S., Ch. 1024.)

6 Source Law

7 Sec. 2. . . . This article does not apply to
8 provisions for dental care benefits in any health
9 insurance policy.

10 Revised Law

11 Sec. 1301.003. PREFERRED PROVIDER BENEFIT PLANS
12 PERMITTED. A health insurance policy that provides different
13 benefits from the basic level of coverage for the use of preferred
14 providers and that meets the requirements of this chapter is not:

- 15 (1) unjust under Chapter 1701;
16 (2) unfair discrimination under Subchapter A or B,
17 Chapter 544; or
18 (3) a violation of Subchapter B or C, Chapter 1451.
19 (V.T.I.C. Art. 3.70-3C, Sec. 3(a), as added Acts 75th Leg., R.S.,
20 Ch. 1024.)

21 Source Law

22 Sec. 3. (a) A health insurance policy that
23 includes different benefits from the basic level of
24 coverage for the use of preferred providers shall not
25 be considered unjust under Article 3.42 of this code,
26 or unfair discrimination under Article 21.21-6, as
27 added by Chapter 415, Acts of the 74th Legislature,
28 1995, or Article 21.21-8 of this code or to violate
29 Subsection (B), Section 2, Chapter 397, Acts of the
30 54th Legislature, 1955 (Article 3.70-2, Vernon's Texas
31 Insurance Code), or Article 21.52 of this code, if it
32 meets the requirements of this section.

33 Revisor's Note

34 Section 3(a), V.T.I.C. Article 3.70-3C, as added
35 by Chapter 1024, Acts of the 75th Legislature, Regular
36 Session, 1997, provides that a health insurance policy
37 establishing a preferred provider benefit plan does
38 not violate certain provisions of law relating to
39 unjust policy provisions, unfair discrimination, and
40 selection of practitioners if the policy meets the

1 requirements of "this section," meaning Section 3,
2 Article 3.70-3C. However, the portion of Section 3
3 revised as Section 1301.004 requires a preferred
4 provider benefit plan to comply with "this article,"
5 meaning all of Article 3.70-3C. Accordingly, the
6 revised law refers to this chapter, rather than the
7 portions of this chapter that were derived from
8 Section 3, Article 3.70-3C.

9 Revised Law

10 Sec. 1301.004. COMPLIANCE WITH CHAPTER REQUIRED. Each
11 preferred provider benefit plan offered in this state must comply
12 with this chapter. (V.T.I.C. Art. 3.70-3C, Sec. 3(1) (part), as
13 added Acts 75th Leg., R.S., Ch. 1024.)

14 Source Law

15 (1) . . . All preferred provider insurance
16 benefit plans offered in this state shall comply with
17 the requirements of this article.

18 Revised Law

19 Sec. 1301.005. AVAILABILITY OF PREFERRED PROVIDERS. (a)
20 An insurer offering a preferred provider benefit plan shall ensure
21 that both preferred provider benefits and basic level benefits are
22 reasonably available to all insureds within a designated service
23 area.

24 (b) If services are not available through a preferred
25 provider within the service area, an insurer shall reimburse a
26 physician or health care provider who is not a preferred provider at
27 the same percentage level of reimbursement as a preferred provider
28 would have been reimbursed had the insured been treated by a
29 preferred provider.

30 (c) Subsection (b) does not require reimbursement at a
31 preferred level of coverage solely because an insured resides out
32 of the service area and chooses to receive services from a provider
33 other than a preferred provider for the insured's own convenience.
34 (V.T.I.C. Art. 3.70-3C, Sec. 8, as added Acts 75th Leg., R.S., Ch.
35 1024.)

1 Acts 75th Leg., R.S., Ch. 1024.)

2 Source Law

3 Sec. 9. The commissioner shall adopt rules as
4 necessary to implement the provisions of this article
5 and to ensure reasonable accessibility and
6 availability of preferred provider and basic level
7 benefits to Texas citizens.

8 Revisor's Note

9 Section 9, V.T.I.C. Article 3.70-3C, refers to
10 "Texas citizens." The revised law substitutes
11 "residents" for "citizens" because, in the context of
12 this section, "citizen" and "resident" are synonymous,
13 and "resident" is more commonly used.

14 [Sections 1301.008-1301.050 reserved for expansion]

15 SUBCHAPTER B. RELATIONS WITH PHYSICIANS OR
16 HEALTH CARE PROVIDERS

17 Revised Law

18 Sec. 1301.051. DESIGNATION AS PREFERRED PROVIDER. (a) An
19 insurer shall afford a fair, reasonable, and equivalent opportunity
20 to apply to be and to be designated as a preferred provider to
21 practitioners and institutional providers and to health care
22 providers other than practitioners and institutional providers, if
23 those other health care providers are included by the insurer as
24 preferred providers, provided that the practitioners,
25 institutional providers, or health care providers:

26 (1) are licensed to treat injuries or illnesses or to
27 provide services covered by a health insurance policy; and

28 (2) comply with the terms established by the insurer
29 for designation as preferred providers.

30 (b) An insurer may not unreasonably withhold a designation
31 as a preferred provider.

32 (c) An insurer shall give a physician or health care
33 provider who, on the person's initial application, is not
34 designated as a preferred provider written reasons for denial of
35 the designation.

36 (d) Unless otherwise limited by this code, this section does

1 not prohibit an insurer from rejecting a physician's or health care
2 provider's application for designation based on a determination
3 that the preferred provider benefit plan has sufficient qualified
4 providers. (V.T.I.C. Art. 3.70-3C, Secs. 3(b)(1), (4), as added
5 Acts 75th Leg., R.S., Ch. 1024.)

6 Source Law

7 (b)(1) Physicians, practitioners, institutional
8 providers, and health care providers other than
9 physicians, practitioners, and institutional
10 providers, if such other health care providers are
11 included by the insurer as preferred providers,
12 licensed to treat injuries or illnesses or to provide
13 services covered by the health insurance policy that
14 comply with the terms and conditions established by
15 the insurer for designation as preferred providers may
16 apply for and shall be afforded a fair, reasonable, and
17 equivalent opportunity to become preferred providers.
18 Such designation shall not be unreasonably withheld.

19 (4) The insurer must give a physician or
20 health care provider not designated on initial
21 application written reasons for denial of the
22 designation; however, unless otherwise limited by
23 this code, this section does not prohibit an insurer
24 from rejecting an application from a physician or
25 health care provider based on a determination that the
26 preferred provider benefit plan has sufficient
27 qualified providers.

28 Revisor's Note

29 (1) Section 3(b)(1), V.T.I.C. Article 3.70-3C,
30 as added by Chapter 1024, Acts of the 75th Legislature,
31 Regular Session, 1997, refers to "physicians [and]
32 practitioners"; similar phrases appear in subsequent
33 sections of Article 3.70-3C. Throughout this chapter,
34 the revised law omits such references to a "physician"
35 as unnecessary. Section 1(9), Article 3.70-3C, in
36 part defines "practitioner" as a person described as a
37 practitioner under Section 2(B), Chapter 397, Acts of
38 the 54th Legislature, Regular Session, 1955 (Article
39 3.70-2, Vernon's Texas Insurance Code). That section,
40 which is revised in relevant part as Section 1451.001,
41 describes a "Doctor of Medicine" licensed in Texas as a
42 practitioner. "Doctor of Medicine" and "physician"
43 are synonymous under Section 104.003(b), Occupations

1 Code.

2 (2) Section 3(b)(1), V.T.I.C. Article 3.70-3C,
3 as added by Chapter 1024, Acts of the 75th Legislature,
4 Regular Session, 1997, refers to the "terms and
5 conditions" established by an insurer for designation
6 as a preferred provider; subsequent sections also use
7 that phrase. Throughout this chapter, the revised law
8 omits references to a "condition" because "condition"
9 is included within the meaning of "term."

10 Revised Law

11 Sec. 1301.052. DESIGNATION OF ADVANCED PRACTICE NURSE OR
12 PHYSICIAN ASSISTANT AS PREFERRED PROVIDER. An insurer offering a
13 preferred provider benefit plan may not refuse a request made by a
14 physician participating as a preferred provider under the plan and
15 an advanced practice nurse or physician assistant to have the
16 advanced practice nurse or physician assistant included as a
17 preferred provider under the plan if:

18 (1) the advanced practice nurse or physician assistant
19 is authorized by the physician to provide care under Subchapter B,
20 Chapter 157, Occupations Code; and

21 (2) the advanced practice nurse or physician assistant
22 meets the quality of care standards previously established by the
23 insurer for participation in the plan by advanced practice nurses
24 and physician assistants. (V.T.I.C. Art. 3.70-3C, Sec. 2, as added
25 Acts 75th Leg., R.S., Ch. 1260.)

26 Source Law

27 Sec. 2. If an advanced practice nurse or
28 physician assistant is authorized to provide care
29 under Section 3.06(d)(5) or (6), Medical Practice Act
30 (Article 4495b, Vernon's Texas Civil Statutes), by a
31 physician participating as a preferred provider under
32 a preferred provider benefit plan, that plan may not
33 refuse a request made by the physician and physician
34 assistant or advanced practice nurse to have the
35 physician assistant or advanced practice nurse
36 included as a preferred provider by the plan unless the
37 physician assistant or advanced practice nurse fails
38 to meet the quality of care standards previously
39 established by the preferred provider benefit plan for
40 participation in the plan by advanced practice nurses
41 and physician assistants.

1 Revisor's Note

2 (1) Section 2, V.T.I.C. Article 3.70-3C, as
3 added by Chapter 1260, Acts of the 75th Legislature,
4 Regular Session, 1997, refers to Sections 3.06(d)(5)
5 and (6), Medical Practice Act (Article 4495b, Vernon's
6 Texas Civil Statutes). Those statutes were codified
7 in 1999 as Subchapter B, Chapter 157, Occupations
8 Code. The revised law is drafted accordingly.

9 (2) Section 3, V.T.I.C. Article 3.70-3C, as
10 added by Chapter 1260, Acts of the 75th Legislature,
11 Regular Session, 1997, prohibits a preferred provider
12 benefit plan from taking certain action in relation to
13 an advanced practice nurse or physician assistant
14 because those practitioners are "not identified under
15 Section 3, Article 21.52, Insurance Code." However,
16 Chapter 428, Acts of the 76th Legislature, Regular
17 Session, 1999, subsequently added those practitioners
18 to Section 3, Article 21.52, and thus impliedly
19 repealed Section 3, V.T.I.C. Article 3.70-3C.
20 Therefore, the revised law omits Section 3, V.T.I.C.
21 Article 3.70-3C. The omitted law reads:

22 Sec. 3. A preferred provider benefit
23 plan may not refuse to contract with an
24 advanced practice nurse or physician
25 assistant to be included in the plan's
26 provider network, refuse to reimburse the
27 advanced practice nurse or physician
28 assistant for covered services, or
29 otherwise discriminate against the advanced
30 practice nurse or physician assistant
31 because the advanced practice nurse or
32 physician assistant is not identified under
33 Section 3, Article 21.52, Insurance Code.

34 Revised Law

35 Sec. 1301.053. APPEAL RELATING TO DESIGNATION AS PREFERRED
36 PROVIDER. (a) An insurer that does not designate a practitioner
37 as a preferred provider shall provide a reasonable mechanism for
38 reviewing that action. The review mechanism must incorporate, in
39 an advisory role only, a review panel.

1 (b) A review panel must be composed of at least three
2 individuals selected by the insurer from a list of participating
3 practitioners and must include one member who is a practitioner in
4 the same or similar specialty as the affected practitioner, if
5 available. The practitioners contracting with the insurer in the
6 applicable service area shall provide the list of practitioners to
7 the insurer.

8 (c) On request, the insurer shall provide to the affected
9 practitioner:

10 (1) the panel's recommendation, if any; and

11 (2) a written explanation of the insurer's
12 determination, if that determination is contrary to the panel's
13 recommendation. (V.T.I.C. Art. 3.70-3C, Secs. 3(b)(2), (3), as
14 added Acts 75th Leg., R.S., Ch. 1024.)

15 Source Law

16 (2) If a designation as a preferred
17 provider is withheld relating to a physician or
18 practitioner, the insurer shall provide a reasonable
19 review mechanism that incorporates, in an advisory
20 role only, a review panel. Any recommendation of the
21 panel shall be provided on request to the affected
22 physician or practitioner. In the event of an insurer
23 determination contrary to any recommendation of the
24 panel, a written explanation of the insurer's
25 determination shall also be provided on request to the
26 affected physician or practitioner.

27 (3) The review panel shall be composed of
28 not less than three individuals selected by the
29 insurer from a list of the physicians or practitioners
30 contracting with the insurer and shall include one
31 member who is a physician or practitioner in the same
32 or similar specialty as the affected physician or
33 practitioner, if available. The list of physicians or
34 practitioners is to be provided to the insurer by the
35 physicians or practitioners contracting with the
36 insurer in the applicable service area.

37 Revised Law

38 Sec. 1301.054. NOTICE TO PRACTITIONERS OF PREFERRED
39 PROVIDER BENEFIT PLAN. (a) When sponsoring a preferred provider
40 benefit plan, an insurer shall immediately notify each practitioner
41 in the plan's service area of the insurer's intent to offer the plan
42 and of the opportunity to participate. The notification must be
43 made by publication or in writing to each practitioner.

44 (b) After establishing a preferred provider benefit plan,

1 an insurer shall annually provide notice of and an opportunity to
2 participate in the plan to practitioners in the plan's service area
3 who do not participate in the plan.

4 (c) On request, an insurer shall provide to any physician or
5 health care provider information concerning the application
6 process and qualification requirements for participation as a
7 preferred provider in the plan. (V.T.I.C. Art. 3.70-3C, Sec. 3(c),
8 as added Acts 75th Leg., R.S., Ch. 1024.)

9 Source Law

10 (c) Any insurer, when sponsoring a preferred
11 provider benefit plan, shall immediately notify, by
12 publication or in writing to each physician and
13 practitioner, all physicians and practitioners in the
14 geographic area covered by the plan of its intent to
15 offer such a plan and of the opportunity to
16 participate. Such notice and opportunity shall be
17 provided on a yearly basis thereafter to
18 noncontracting physicians and practitioners in the
19 geographic area covered by the plan. The insurer shall
20 on request make available to any physician or health
21 care provider information concerning the application
22 process and qualification requirements for
23 participation as a provider in the plan.

24 Revisor's Note

25 Section 3(c), V.T.I.C. Article 3.70-3C, as added
26 by Chapter 1024, Acts of the 75th Legislature, Regular
27 Session, 1997, refers to "the geographic area covered
28 by the plan." The revised law substitutes "the plan's
29 service area" for the quoted language because "service
30 area" is the defined term under Section 1(13), Article
31 3.70-3C, as added by Chapter 1024, Acts of the 75th
32 Legislature, Regular Session, 1997, revised as Section
33 1301.001(10).

34 Revised Law

35 Sec. 1301.055. COMPLAINT RESOLUTION. (a) Each contract
36 under a preferred provider benefit plan between an insurer and a
37 physician or other practitioner or a physicians' group must have a
38 mechanism for resolving complaints initiated by an insured, a
39 physician or other practitioner, or a physicians' group.

40 (b) A complaint resolution mechanism must provide for

1 reasonable due process that includes, in an advisory role only, a
2 review panel selected in the manner described by Section
3 1301.053(b). (V.T.I.C. Art. 3.70-3C, Sec. 3(f), as added Acts 75th
4 Leg., R.S., Ch. 1024.)

5 Source Law

6 (f) Every contract by an insurer with a
7 physician, physicians group, or practitioner shall
8 have a mechanism for the resolution of complaints
9 initiated by the insured, physicians, physicians
10 groups, or practitioners. Such mechanism shall
11 provide for reasonable due process which includes, in
12 an advisory role only, a review panel selected in the
13 manner described in Subsection (b)(3) of this section.

14 Revised Law

15 Sec. 1301.056. RESTRICTIONS ON PAYMENT AND REIMBURSEMENT.

16 (a) An insurer or third-party administrator may not reimburse a
17 physician or other practitioner, institutional provider, or
18 organization of physicians and health care providers on a
19 discounted fee basis for covered services that are provided to an
20 insured unless:

21 (1) the insurer or third-party administrator has
22 contracted with either:

23 (A) the physician or other practitioner,
24 institutional provider, or organization of physicians and health
25 care providers; or

26 (B) a preferred provider organization that has a
27 network of preferred providers and that has contracted with the
28 physician or other practitioner, institutional provider, or
29 organization of physicians and health care providers;

30 (2) the physician or other practitioner,
31 institutional provider, or organization of physicians and health
32 care providers has agreed to the contract and has agreed to provide
33 health care services under the terms of the contract; and

34 (3) the insurer or third-party administrator has
35 agreed to provide coverage for those health care services under the
36 health insurance policy.

37 (b) A party to a preferred provider contract, including a

1 contract with a preferred provider organization, may not sell,
2 lease, or otherwise transfer information regarding the payment or
3 reimbursement terms of the contract without the express authority
4 of and prior adequate notification to the other contracting
5 parties. This subsection does not affect the authority of the
6 commissioner or the Texas Workers' Compensation Commission under
7 this code to request and obtain information.

8 (c) An insurer or third-party administrator who violates
9 this section:

10 (1) commits an unfair claim settlement practice in
11 violation of Subchapter A, Chapter 542; and

12 (2) is subject to administrative penalties under
13 Chapters 82 and 84. (V.T.I.C. Art. 3.70-3C, Sec. 7A, as added Acts
14 75th Leg., R.S., Ch. 1024.)

15 Source Law

16 Sec. 7A. (a) An insurer or third party
17 administrator may not reimburse a physician,
18 practitioner, hospital, institutional provider, or
19 organization of physicians and health care providers
20 on a discounted fee basis for covered services that are
21 provided to an insured unless:

22 (1) the insurer or third party
23 administrator has contracted with either:

24 (A) the physician, practitioner,
25 hospital, institutional provider, organization of
26 physicians and health care providers; or

27 (B) a preferred provider
28 organization that has a network of preferred providers
29 and such organization has contracted with the health
30 care preferred provider;

31 (2) the physician, practitioner,
32 hospital, institutional provider, or organization of
33 physicians and health care providers has agreed to the
34 contract and has agreed to provide health care
35 services under the terms of the contract; and

36 (3) the insurer or third party
37 administrator has agreed to provide coverage for those
38 health care services under the health insurance
39 policy.

40 (b) A party to a preferred provider contract,
41 including a contract with a preferred provider
42 organization, may not sell, lease, or otherwise
43 transfer information regarding the payment or
44 reimbursement terms of the contract without the
45 express authority and prior adequate notification of
46 the other contracting parties. This subsection does
47 not affect the authority of the commissioner or the
48 Texas Workers' Compensation Commission under this code
49 to request and obtain information.

50 (c) An insurer or third party administrator who
51 violates this section commits an unfair claim
52 settlement practice in violation of Article 21.21-2 of

1 this code and is also subject to administrative
2 penalties under Articles 1.10 and 1.10E of this code.

3 Revisor's Note

4 Section 7A(a), V.T.I.C. Article 3.70-3C, as added
5 by Chapter 1024, Acts of the 75th Legislature, Regular
6 Session, 1997, refers to a "hospital [or]
7 institutional provider." The revised law omits the
8 reference to "hospital" because "hospital" is included
9 within the meaning of "institutional provider" under
10 Section 1(5), V.T.I.C. Article 3.70-3C, as added by
11 Chapter 1024, Acts of the 75th Legislature, Regular
12 Session, 1997, revised as Section 1301.001(4).

13 Revised Law

14 Sec. 1301.057. TERMINATION OF PARTICIPATION; EXPEDITED
15 REVIEW PROCESS. (a) Before terminating a contract with a
16 preferred provider, an insurer shall:

17 (1) provide written reasons for the termination; and

18 (2) if the affected provider is a practitioner,
19 provide, on request, a reasonable review mechanism, except in a
20 case involving:

21 (A) imminent harm to a patient's health;

22 (B) an action by a state medical or other
23 physician licensing board or other government agency that
24 effectively impairs the practitioner's ability to practice
25 medicine; or

26 (C) fraud or malfeasance.

27 (b) The review mechanism described by Subsection (a)(2)
28 must incorporate, in an advisory role only, a review panel selected
29 in the manner described by Section 1301.053(b) and must be
30 completed within a period not to exceed 60 days.

31 (c) The insurer shall provide to the affected practitioner:

32 (1) the panel's recommendation, if any; and

33 (2) on request, a written explanation of the insurer's
34 determination, if that determination is contrary to the panel's
35 recommendation.

1 (d) On request, an insurer shall make an expedited review
2 available to a practitioner whose participation in a preferred
3 provider benefit plan is being terminated. The expedited review
4 process must comply with rules established by the commissioner.
5 (V.T.I.C. Art. 3.70-3C, Sec. 3(g), as added Acts 75th Leg., R.S.,
6 Ch. 1024.)

7 Source Law

8 (g) Before terminating a contract with a
9 preferred provider, the insurer shall provide written
10 reasons for the termination. Prior to termination of a
11 physician or practitioner, but within a period not to
12 exceed 60 days, the insurer shall, on request, provide
13 a reasonable review mechanism that incorporates, in an
14 advisory role only, a review panel selected in the
15 manner described in Subsection (b)(3) of this section,
16 except in cases in which there is imminent harm to a
17 patient's health or an action by a state medical or
18 other physician licensing board or other government
19 agency that effectively impairs a physician's or
20 practitioner's ability to practice medicine or in
21 cases of fraud or malfeasance. Any recommendation of
22 the panel shall be provided to the affected physician
23 or practitioner. In the event of an insurer
24 determination contrary to any recommendation of the
25 panel, a written explanation of the insurer's
26 determination shall also be provided on request to the
27 affected physician or practitioner. On request, an
28 expedited review process shall be made available to a
29 physician or practitioner who is being terminated.
30 The expedited review process shall comply with rules
31 established by the commissioner.

32 Revised Law

33 Sec. 1301.058. ECONOMIC PROFILING. An insurer that
34 conducts, uses, or relies on economic profiling to admit or
35 terminate the participation of physicians or health care providers
36 in a preferred provider benefit plan shall make available to a
37 physician or health care provider on request the economic profile
38 of that physician or health care provider, including the written
39 criteria by which the physician or health care provider's
40 performance is to be measured. An economic profile must be adjusted
41 to recognize the characteristics of a physician's or health care
42 provider's practice that may account for variations from expected
43 costs. (V.T.I.C. Art. 3.70-3C, Sec. 3(h), as added Acts 75th Leg.,
44 R.S., Ch. 1024.)

1 Source Law

2 (h) An insurer that conducts, uses, or relies on
3 economic profiling to admit or terminate physicians or
4 health care providers shall make available to a
5 physician or health care provider on request the
6 economic profile of that physician or health care
7 provider, including the written criteria by which the
8 physician or health care provider's performance is to
9 be measured. An economic profile must be adjusted to
10 recognize the characteristics of a physician's or
11 health care provider's practice that may account for
12 variations from expected costs.

13 Revised Law

14 Sec. 1301.059. QUALITY ASSESSMENT. (a) In this section,
15 "quality assessment" means a mechanism used by an insurer to
16 evaluate, monitor, or improve the quality and effectiveness of the
17 medical care delivered by physicians or health care providers to
18 persons covered by a health insurance policy to ensure that the care
19 delivered is consistent with the care delivered by an ordinary,
20 reasonable, and prudent physician or health care provider under the
21 same or similar circumstances.

22 (b) An insurer may not engage in quality assessment except
23 through a panel of at least three physicians selected by the insurer
24 from among a list of physicians contracting with the insurer. The
25 physicians contracting with the insurer in the applicable service
26 area shall provide the list of physicians to the insurer. (V.T.I.C.
27 Art. 3.70-3C, Secs. 1(12), 3(i), as added Acts 75th Leg., R.S., Ch.
28 1024.)

29 Source Law

30 [Sec. 1]

31 (12) "Quality assessment" means a
32 mechanism which is in place or put into place and
33 utilized by an insurer for the purposes of evaluating,
34 monitoring, or improving the quality and effectiveness
35 of the medical care delivered by physicians or health
36 care providers to persons covered by a health
37 insurance policy to ensure that the care delivered is
38 consistent with that delivered by an ordinary,
39 reasonable, prudent physician or health care provider
40 under the same or similar circumstances.

41 [Sec. 3]

42 (i) No insurer shall engage in quality
43 assessment except through a panel of not less than
44 three physicians selected by the insurer from among a
45 list of physicians contracting with the insurer, which
46 list is to be provided by the physicians contracting
47 with the insurer in the applicable service area.

1 Revised Law

2 Sec. 1301.060. COMPENSATION ON DISCOUNTED FEE BASIS. A
3 preferred provider contract must include a provision by which the
4 physician or health care provider agrees that if the preferred
5 provider is compensated on a discounted fee basis, the insured may
6 be billed only on the discounted fee and not the full charge.
7 (V.T.I.C. Art. 3.70-3C, Sec. 3(k), as added Acts 75th Leg., R.S.,
8 Ch. 1024.)

9 Source Law

10 (k) A preferred provider contract must include a
11 provision by which the physician or health care
12 provider agrees that if the preferred provider is
13 compensated on a discounted fee basis, the insured may
14 be billed only on the discounted fee and not the full
15 charge.

16 Revised Law

17 Sec. 1301.061. PREFERRED PROVIDER NETWORKS. (a) An
18 insurer may enter into an agreement with a preferred provider
19 organization for the purposes of offering a network of preferred
20 providers. The agreement may provide that either the insurer or the
21 preferred provider organization on the insurer's behalf will comply
22 with the notice requirements and other requirements imposed on the
23 insurer by this subchapter.

24 (b) An insurer that enters into an agreement with a
25 preferred provider organization under this section shall meet the
26 requirements of this chapter or ensure that those requirements are
27 met. (V.T.I.C. Art. 3.70-3C, Sec. 3(l) (part), as added Acts 75th
28 Leg., R.S., Ch. 1024.)

29 Source Law

30 (l) An insurer may enter into an agreement with
31 a preferred provider organization for the purposes of
32 offering a network of preferred providers. The
33 agreement may provide that the notice and other
34 insurer requirements of this section may be complied
35 with by either the insurer or the preferred provider
36 organization on the insurer's behalf. If an insurer
37 enters into an agreement with a preferred provider
38 organization under this section, it is the insurer's
39 responsibility to meet the requirements of this
40 article or to assure that the requirements are
41 met. . . .

1 Revised Law

2 Sec. 1301.062. PREFERRED PROVIDER CONTRACTS BETWEEN
3 INSURERS AND PODIATRISTS. A preferred provider contract between
4 an insurer and a podiatrist licensed by the Texas State Board of
5 Podiatric Medical Examiners must provide that:

6 (1) the podiatrist may request a copy of the coding
7 guidelines and payment schedules applicable to the compensation
8 that the podiatrist will receive under the contract for services;

9 (2) the insurer shall provide a copy of the coding
10 guidelines and payment schedules not later than the 30th day after
11 the date of the podiatrist's request;

12 (3) the insurer may not unilaterally make material
13 retroactive revisions to the coding guidelines and payment
14 schedules; and

15 (4) the podiatrist may, practicing within the scope of
16 the law regulating podiatry, furnish x-rays and nonprefabricated
17 orthotics covered by the health insurance policy. (V.T.I.C.
18 Art. 3.70-3C, Sec. 3(n), as added Acts 75th Leg., R.S., Ch. 1024.)

19 Source Law

20 (n) A preferred provider contract between an
21 insurer and a podiatrist licensed by the Texas State
22 Board of Podiatric Medical Examiners must provide
23 that:

24 (1) the podiatrist may request, and the
25 insurer shall provide not later than the 30th day after
26 the date of the request, a copy of the coding
27 guidelines and payment schedules applicable to the
28 compensation that the podiatrist will receive under
29 the contract for services;

30 (2) the insurer may not unilaterally make
31 material retroactive revisions to the coding
32 guidelines and payment schedules; and

33 (3) the podiatrist may, practicing within
34 the scope of the law regulating podiatry, furnish
35 x-rays and nonprefabricated orthotics covered by the
36 health insurance policy.

37 Revised Law

38 Sec. 1301.063. CONTRACT PROVISIONS RELATING TO USE OF
39 HOSPITALIST. (a) In this section, "hospitalist" means a
40 physician who:

41 (1) serves as physician of record at a hospital for a
42 hospitalized patient of another physician; and

1 (2) returns the care of the patient to that other
2 physician at the end of the patient's hospitalization.

3 (b) A preferred provider contract between an insurer and a
4 physician may not require the physician to use a hospitalist for a
5 hospitalized patient. (V.T.I.C. Art. 3.70-3C, Sec. 3B, as added
6 Acts 75th Leg., R.S., Ch. 1024.)

7 Source Law

8 Sec. 3B. (a) In this section, "hospitalist"
9 means a physician who:

10 (1) serves as physician of record at a
11 hospital for a hospitalized patient of another
12 physician; and

13 (2) returns the care of the patient to that
14 other physician at the end of the patient's
15 hospitalization.

16 (b) A preferred provider contract between an
17 insurer and a physician may not require the physician
18 to use a hospitalist for a hospitalized patient.

19 Revised Law

20 Sec. 1301.064. CONTRACT PROVISIONS RELATING TO PAYMENT OF
21 CLAIMS. Subject to Subchapter C, a preferred provider contract
22 must provide for payment to a physician or health care provider for
23 health care services and benefits provided to an insured under the
24 contract and to which the insured is entitled under the terms of the
25 contract not later than:

26 (1) the 45th day after the date on which a claim for
27 payment is received with the documentation reasonably necessary to
28 process the claim; or

29 (2) if applicable, within the number of calendar days
30 specified by written agreement between the physician or health care
31 provider and the insurer. (V.T.I.C. Art. 3.70-3C, Sec. 3(m)
32 (part), as added Acts 75th Leg., R.S., Ch. 1024.)

33 Source Law

34 (m) . . . A preferred provider contract must
35 include a provision for payment to the physician or
36 health care provider for covered services that are
37 rendered to insureds under the contract not later than
38 the 45th day after the date on which a claim for
39 payment is received with the documentation reasonably
40 necessary to process the claim or, if applicable,
41 within the number of calendar days specified by
42 written agreement between the physician or health care
43 provider and the insurer. For purposes of this
44 subsection, "covered services" means health care

1 services and benefits to which an insured is entitled
2 under the terms of the contract.

3 Revisor's Note

4 Section 3(m), V.T.I.C. Article 3.70-3C, as added
5 by Chapter 1024, Acts of the 75th Legislature, Regular
6 Session, 1997, prescribes certain provisions relating
7 to payment for covered services that must be contained
8 in a contract between an insurer and a preferred
9 provider. Article 3.70-3C, as added by Chapter 1024,
10 Acts of the 75th Legislature, Regular Session, 1997,
11 was amended by the addition of Section 3A by Chapter
12 1343, Acts of the 76th Legislature, Regular Session,
13 1999. Section 3A, which is revised as Subchapter C of
14 this chapter, provides for payment of certain "clean
15 claims" submitted by a preferred provider. Section
16 312.014(a), Government Code, provides that "[i]f
17 statutes enacted at . . . different sessions of the
18 legislature are irreconcilable, the statute latest in
19 date of enactment prevails." Thus, as the later
20 enactment, Section 3A prevails over Section 3(m) to
21 the extent of any conflict. Accordingly, the revised
22 law includes a reference to Subchapter C.

23 Revised Law

24 Sec. 1301.065. SHIFTING OF INSURER'S TORT LIABILITY
25 PROHIBITED. A preferred provider contract may not require any
26 physician, health care provider, or physicians' group to execute a
27 hold harmless clause to shift the insurer's tort liability
28 resulting from the insurer's acts or omissions to the preferred
29 provider. (V.T.I.C. Art. 3.70-3C, Sec. 3(j), as added Acts 75th
30 Leg., R.S., Ch. 1024.)

31 Source Law

32 (j) A preferred provider contract may not
33 require any health care provider, physician, or
34 physicians group to execute hold harmless clauses in
35 order to shift the insurer's tort liability resulting
36 from acts or omissions of the insurer to the preferred
37 provider.

1 Revised Law

2 Sec. 1301.066. RETALIATION AGAINST PREFERRED PROVIDER
3 PROHIBITED. An insurer may not engage in any retaliatory action
4 against a physician or health care provider, including terminating
5 the physician's or provider's participation in the preferred
6 provider benefit plan or refusing to renew the physician's or
7 provider's contract, because the physician or provider has:

8 (1) on behalf of an insured, reasonably filed a
9 complaint against the insurer; or

10 (2) appealed a decision of the insurer. (V.T.I.C.
11 Art. 3.70-3C, Sec. 7(b), as added Acts 75th Leg., R.S., Ch. 1024.)

12 Source Law

13 (b) No insurer shall engage in any retaliatory
14 action against a physician or health care provider,
15 including termination of or refusal to renew a
16 contract, because the physician or provider has, on
17 behalf of an insured, reasonably filed a complaint
18 against the insurer or has appealed a decision of the
19 insurer.

20 Revised Law

21 Sec. 1301.067. INTERFERENCE WITH RELATIONSHIP BETWEEN
22 PATIENT AND PHYSICIAN OR HEALTH CARE PROVIDER PROHIBITED. (a) An
23 insurer may not, as a condition of a preferred provider contract
24 with a physician or health care provider or in any other manner,
25 prohibit, attempt to prohibit, or discourage a physician or
26 provider from discussing with or communicating to a current,
27 prospective, or former patient, or a person designated by a
28 patient, information or an opinion:

29 (1) regarding the patient's health care, including the
30 patient's medical condition or treatment options; or

31 (2) in good faith regarding the provisions, terms,
32 requirements, or services of the health insurance policy as they
33 relate to the patient's medical needs.

34 (b) An insurer may not in any way penalize, terminate the
35 participation of, or refuse to compensate for covered services a
36 physician or health care provider for discussing or communicating
37 with a current, prospective, or former patient, or a person

1 designated by a patient, pursuant to this section. (V.T.I.C.
2 Art. 3.70-3C, Sec. 7(c), as added Acts 75th Leg., R.S., Ch. 1024.)

3 Source Law

4 (c)(1) An insurer shall not, as a condition of a
5 contract with a physician or health care provider or in
6 any other manner, prohibit, attempt to prohibit, or
7 discourage a physician or provider from:

8 (A) discussing with or communicating
9 to a current, prospective, or former patient, or a
10 party designated by a patient, information or opinions
11 regarding that patient's health care, including but
12 not limited to the patient's medical condition or
13 treatment options; or

14 (B) discussing with or communicating
15 in good faith to a current, prospective, or former
16 patient, or a party designated by a patient,
17 information or opinions regarding the provisions,
18 terms, requirements, or services of the health care
19 plan as they relate to the medical needs of the
20 patient.

21 (2) An insurer shall not in any way
22 penalize, terminate, or refuse to compensate for
23 covered services a physician or provider for
24 discussing or communicating with a current,
25 prospective, or former patient, or a party designated
26 by a patient, pursuant to this section.

27 Revisor's Note

28 (1) Section 7(c)(1)(A), V.T.I.C. Article
29 3.70-3C, as added by Chapter 1024, Acts of the 75th
30 Legislature, Regular Session, 1997, refers to
31 "including but not limited to." Throughout this
32 chapter, the revised law omits "but not limited to" as
33 unnecessary because Section 311.005(13), Government
34 Code (Code Construction Act), applicable to the
35 revised law, provides that "includes" and "including"
36 are terms of enlargement and not of limitation and do
37 not create a presumption that components not expressed
38 are excluded.

39 (2) Section 7(c)(1)(B), V.T.I.C. Article
40 3.70-3C, as added by Chapter 1024, Acts of the 75th
41 Legislature, Regular Session, 1997, refers to a
42 "health care plan." For consistency throughout this
43 chapter, the revised law substitutes the defined term
44 "health insurance policy" for "health care plan."

1 Revised Law

2 Sec. 1301.068. INDUCEMENT TO LIMIT MEDICALLY NECESSARY
3 SERVICES PROHIBITED. (a) An insurer may not use any financial
4 incentive or make payment to a physician or health care provider
5 that acts directly or indirectly as an inducement to limit
6 medically necessary services.

7 (b) This section does not prohibit the use of capitation as
8 a method of payment. (V.T.I.C. Art. 3.70-3C, Sec. 7(d), as added
9 Acts 75th Leg., R.S., Ch. 1024.)

10 Source Law

11 (d) An insurer shall not use any financial
12 incentive or make payment to a physician or health care
13 provider which acts directly or indirectly as an
14 inducement to limit medically necessary services.
15 This subsection does not prohibit the use of
16 capitation as a method of payment.

17 [Sections 1301.069-1301.100 reserved for expansion]

18 SUBCHAPTER C. PAYMENT OF CLAIMS TO PROVIDERS

19 Revised Law

20 Sec. 1301.101. DEFINITION. In this subchapter, "clean
21 claim" means a completed claim, as determined under department
22 rules, submitted by a preferred provider for medical care or health
23 care services under a health insurance policy. (V.T.I.C.
24 Art. 3.70-3C, Sec. 3A(a), as added Acts 75th Leg., R.S., Ch. 1024.)

25 Source Law

26 Sec. 3A. (a) In this section, "clean claim"
27 means a completed claim, as determined under
28 department rules, submitted by a preferred provider
29 for medical care or health care services under a health
30 insurance policy.

31 Revised Law

32 Sec. 1301.102. ACKNOWLEDGMENT OF RECEIPT OF CLAIM. (a) A
33 preferred provider may obtain acknowledgment of receipt of a claim
34 for medical care or health care services under a health insurance
35 policy by submitting the claim by United States mail, return
36 receipt requested.

37 (b) An insurer or the contracted clearinghouse of an insurer
38 that receives a claim electronically shall acknowledge receipt of

1 the claim by an electronic transmission to the preferred provider
2 and is not required to acknowledge receipt of the claim in writing.
3 (V.T.I.C. Art. 3.70-3C, Sec. 3A(b), as added Acts 75th Leg., R.S.,
4 Ch. 1024.)

5 Source Law

6 (b) A preferred provider for medical care or
7 health care services under a health insurance policy
8 may obtain acknowledgment of receipt of a claim for
9 medical care or health care services under a health
10 care plan by submitting the claim by United States
11 mail, return receipt requested. An insurer or the
12 contracted clearinghouse of an insurer that receives a
13 claim electronically shall acknowledge receipt of the
14 claim by an electronic transmission to the preferred
15 provider and is not required to acknowledge receipt of
16 the claim by the insurer in writing.

17 Revisor's Note

18 (1) Section 3A(b), V.T.I.C. Article 3.70-3C, as
19 added by Chapter 1024, Acts of the 75th Legislature,
20 Regular Session, 1997, refers to a "preferred provider
21 for medical care or health care services under a health
22 insurance policy." The revised law omits "for medical
23 care or health care services under a health insurance
24 policy" as unnecessary because those concepts are
25 included in the definition of "preferred provider"
26 under Section 1(10), V.T.I.C. Article 3.70-3C, as
27 added by Chapter 1024, Acts of the 75th Legislature,
28 Regular Session, 1997, revised as Section 1301.001(8).

29 (2) Section 3A(b), V.T.I.C. Article 3.70-3C, as
30 added by Chapter 1024, Acts of the 75th Legislature,
31 Regular Session, 1997, refers to a "health care plan."
32 The revised law substitutes "health insurance policy"
33 for "health care plan" for the reason stated in
34 Revisor's Note (2) to Section 1301.067.

35 Revised Law

36 Sec. 1301.103. DEADLINE FOR ACTION ON CLEAN CLAIMS. Not
37 later than the 45th day after the date on which an insurer receives
38 a clean claim from a preferred provider, the insurer shall:

39 (1) pay the total amount of the claim in accordance

1 with the contract between the preferred provider and the insurer;

2 (2) pay the portion of the claim that is not in dispute
3 and notify the preferred provider in writing why the remaining
4 portion of the claim will not be paid; or

5 (3) notify the preferred provider in writing why the
6 claim will not be paid. (V.T.I.C. Art. 3.70-3C, Sec. 3A(c), as
7 added Acts 75th Leg., R.S., Ch. 1024.)

8 Source Law

9 (c) Not later than the 45th day after the date
10 that the insurer receives a clean claim from a
11 preferred provider, the insurer shall:

12 (1) pay the total amount of the claim in
13 accordance with the contract between the preferred
14 provider and the insurer;

15 (2) pay the portion of the claim that is
16 not in dispute and notify the preferred provider in
17 writing why the remaining portion of the claim will not
18 be paid; or

19 (3) notify the preferred provider in
20 writing why the claim will not be paid.

21 Revised Law

22 Sec. 1301.104. DEADLINE FOR ACTION ON CERTAIN PRESCRIPTION
23 BENEFIT CLAIMS. If a preferred provider or its designated agent
24 authorizes treatment, a prescription benefit claim that is
25 electronically adjudicated and electronically paid shall be paid
26 not later than the 21st day after the date on which the treatment is
27 authorized. (V.T.I.C. Art. 3.70-3C, Sec. 3A(d), as added Acts 75th
28 Leg., R.S., Ch. 1024.)

29 Source Law

30 (d) If a prescription benefit claim is
31 electronically adjudicated and electronically paid,
32 and the preferred provider or its designated agent
33 authorizes treatment, the claim must be paid not later
34 than the 21st day after the treatment is authorized.

35 Revised Law

36 Sec. 1301.105. AUDITED CLAIMS. An insurer that
37 acknowledges coverage of an insured under a health insurance policy
38 but intends to audit a claim submitted by a preferred provider shall
39 pay the charges submitted at 85 percent of the contracted rate on
40 the claim not later than the 45th day after the date on which the
41 insurer receives the claim from the preferred provider. Following

1 completion of the audit, any additional payment due a preferred
2 provider or any refund due the insurer shall be made not later than
3 the 30th day after the later of the date that:

4 (1) the preferred provider receives notice of the
5 audit results; or

6 (2) any appeal rights of the insured are exhausted.

7 (V.T.I.C. Art. 3.70-3C, Sec. 3A(e), as added Acts 75th Leg., R.S.,
8 Ch. 1024.)

9 Source Law

10 (e) If the insurer acknowledges coverage of an
11 insured under the health insurance policy but intends
12 to audit the preferred provider claim, the insurer
13 shall pay the charges submitted at 85 percent of the
14 contracted rate on the claim not later than the 45th
15 day after the date that the insurer receives the claim
16 from the preferred provider. Following completion of
17 the audit, any additional payment due a preferred
18 provider or any refund due the insurer shall be made
19 not later than the 30th day after the later of the date
20 that:

21 (1) the preferred provider receives notice
22 of the audit results; or

23 (2) any appeal rights of the insured are
24 exhausted.

25 Revised Law

26 Sec. 1301.106. CLAIMS PROCESSING PROCEDURES. (a) An
27 insurer shall provide a preferred provider with copies of all
28 applicable utilization review policies and claim processing
29 policies or procedures, including required data elements and claim
30 formats.

31 (b) An insurer may, by contract with a preferred provider,
32 add or change the data elements that must be submitted with a claim.

33 (c) Not later than the 60th day before the date of an
34 addition or change in the data elements that must be submitted with
35 a claim or any other change in an insurer's claim processing and
36 payment procedures, the insurer shall provide written notice of the
37 addition or change to each preferred provider. (V.T.I.C.
38 Art. 3.70-3C, Secs. 3A(i), (j), (k), as added Acts 75th Leg., R.S.,
39 Ch. 1024.)

40 Source Law

41 (i) The insurer shall provide a preferred

1 provider with copies of all applicable utilization
2 review policies and claim processing policies or
3 procedures, including required data elements and claim
4 formats.

5 (j) An insurer may, by contract with a preferred
6 provider, add or change the data elements that must be
7 submitted with the preferred provider claim.

8 (k) Not later than the 60th day before the date
9 of an addition or change in the data elements that must
10 be submitted with a claim or any other change in an
11 insurer's claim processing and payment procedures, the
12 insurer shall provide written notice of the addition
13 or change to each preferred provider.

14 Revised Law

15 Sec. 1301.107. VIOLATION OF CLAIMS PAYMENT PROVISIONS;
16 ADMINISTRATIVE PENALTY. (a) An insurer that violates Section
17 1301.103 or 1301.105 is liable to a preferred provider for the full
18 amount of billed charges submitted on the claim or the amount
19 payable under the contracted penalty rate, less any amount
20 previously paid or any charge for a service that is not covered by
21 the health insurance policy.

22 (b) In addition to any other penalty or remedy authorized by
23 this code or another insurance law of this state, an insurer that
24 violates Section 1301.103 or 1301.105 is subject to an
25 administrative penalty under Chapter 84. The administrative
26 penalty imposed under that chapter may not exceed \$1,000 for each
27 day the claim remains unpaid in violation of Section 1301.103 or
28 1301.105. (V.T.I.C. Art. 3.70-3C, Secs. 3A(f), (h), as added Acts
29 75th Leg., R.S., Ch. 1024.)

30 Source Law

31 (f) An insurer that violates Subsection (c) or
32 (e) of this section is liable to a preferred provider
33 for the full amount of billed charges submitted on the
34 claim or the amount payable under the contracted
35 penalty rate, less any amount previously paid or any
36 charge for a service that is not covered by the health
37 insurance policy.

38 (h) In addition to any other penalty or remedy
39 authorized by this code or another insurance law of
40 this state, an insurer that violates Subsection (c) or
41 (e) of this section is subject to an administrative
42 penalty under Article 1.10E of this code. The
43 administrative penalty imposed under that article may
44 not exceed \$1,000 for each day the claim remains unpaid
45 in violation of Subsection (c) or (e) of this section.

46 Revised Law

47 Sec. 1301.108. ATTORNEY'S FEES. A preferred provider may

1 recover reasonable attorney's fees in an action to recover payment
2 under this subchapter. (V.T.I.C. Art. 3.70-3C, Sec. 3A(g), as
3 added Acts 75th Leg., R.S., Ch. 1024.)

4 Source Law

5 (g) A preferred provider may recover reasonable
6 attorney's fees in an action to recover payment under
7 this section.

8 Revised Law

9 Sec. 1301.109. APPLICABILITY TO ENTITIES CONTRACTING WITH
10 INSURER. This subchapter applies to a person with whom an insurer
11 contracts to:

12 (1) process claims; or

13 (2) obtain the services of a preferred provider to
14 provide medical care or health care to an insured under a health
15 insurance policy. (V.T.I.C. Art. 3.70-3C, Sec. 3A(m), as added
16 Acts 75th Leg., R.S., Ch. 1024.)

17 Source Law

18 (m) This section applies to a person with whom
19 an insurer contracts to process claims or to obtain the
20 services of preferred providers to provide medical
21 care or health care to insureds under a health
22 insurance policy.

23 Revised Law

24 Sec. 1301.110. EXCEPTION. This subchapter does not apply
25 to a claim submitted by a preferred provider who is a member of the
26 legislature. (V.T.I.C. Art. 3.70-3C, Sec. 3A(l), as added Acts
27 75th Leg., R.S., Ch. 1024.)

28 Source Law

29 (l) This section does not apply to a claim made
30 by a preferred provider who is a member of the
31 legislature.

32 Revisor's Note
33 (End of Subchapter)

34 Section 3A(n), V.T.I.C. Article 3.70-3C, as added
35 by Chapter 1024, Acts of the 75th Legislature, Regular
36 Session, 1997, authorizes the commissioner of
37 insurance to adopt rules as necessary to implement
38 Section 3A, Article 3.70-3C, revised as this

1 subchapter. The revised law omits this provision as
2 unnecessary because Section 9, Article 3.70-3C, as
3 added by Chapter 1024, Acts of the 75th Legislature,
4 Regular Session, 1997, revised as Section 1301.007,
5 requires the commissioner of insurance to adopt rules
6 to implement Article 3.70-3C, including Section 3A.
7 The omitted law reads:

8 (n) The commissioner of insurance may
9 adopt rules as necessary to implement this
10 section.

11 [Sections 1301.111-1301.150 reserved for expansion]

12 SUBCHAPTER D. RELATIONS BETWEEN INSUREDS AND
13 PREFERRED PROVIDERS

14 Revised Law

15 Sec. 1301.151. INSURED'S RIGHT TO TREATMENT. Each insured
16 is entitled to treatment and diagnostic techniques that are
17 prescribed by the physician or health care provider included in the
18 preferred provider benefit plan. (V.T.I.C. Art. 3.70-3C, Sec.
19 3(e), as added Acts 75th Leg., R.S., Ch. 1024.)

20 Source Law

21 (e) Each insured patient shall have the right to
22 treatment and diagnostic techniques as prescribed by
23 the physician or other health care provider included
24 in the preferred provider benefit plan.

25 Revisor's Note

26 Section 3(e), V.T.I.C. Article 3.70-3C, as added
27 by Chapter 1024, Acts of the 75th Legislature, Regular
28 Session, 1997, refers to an "insured patient." The
29 revised law substitutes "insured" for "insured
30 patient" for consistency throughout this chapter.

31 Revised Law

32 Sec. 1301.152. CONTINUING CARE IN GENERAL. (a) An
33 insurer shall establish reasonable procedures for ensuring a
34 transition of insureds to physicians or health care providers and
35 for continuity of treatment.

36 (b) An insurer shall:

1 (1) provide, subject to Section 1301.160, reasonable
2 advance notice to an insured of the impending termination of the
3 participation in the plan of a physician or health care provider who
4 is currently treating the insured; and

5 (2) in the event of termination of a preferred
6 provider's participation in the plan, make available to the insured
7 a current listing of preferred providers.

8 (c) A contract between an insurer and a physician or health
9 care provider must include a procedure for resolving disputes
10 regarding the necessity for continued treatment by the physician or
11 provider. (V.T.I.C. Art. 3.70-3C, Secs. 4(a), (d), as added Acts
12 75th Leg., R.S., Ch. 1024.)

13 Source Law

14 Sec. 4. (a) The insurer shall establish
15 reasonable procedures for assuring a transition of
16 insureds to physicians or health care providers and
17 for continuity of treatment. Insurers shall provide,
18 subject to Section 6(e) of this article, reasonable
19 advance notice to the insured of the impending
20 termination from the plan of a physician or health care
21 provider who is currently treating the insured and in
22 the event of termination of a preferred provider's
23 participation in the plan shall make available to the
24 insured a current listing of preferred providers.

25 (d) Contracts between an insurer, physicians,
26 and health care providers shall include procedures for
27 resolving disputes regarding the necessity for
28 continued treatment by a physician or provider.

29 Revised Law

30 Sec. 1301.153. CONTINUITY OF CARE. (a) In this section:

31 (1) "Life-threatening" means a disease or condition
32 for which the likelihood of death is probable unless the course of
33 the disease or condition is interrupted.

34 (2) "Special circumstances" means a condition
35 regarding which the treating physician or health care provider
36 reasonably believes that discontinuing care by the treating
37 physician or provider could cause harm to the insured. Examples of
38 an insured who has a special circumstance include an insured with a
39 disability, acute condition, or life-threatening illness or an
40 insured who is past the 24th week of pregnancy.

1 (b) Each contract between an insurer and a physician or
2 health care provider must provide that the termination of the
3 physician's or provider's participation in a preferred provider
4 benefit plan, except for reason of medical competence or
5 professional behavior, does not:

6 (1) release the physician or health care provider from
7 the generally recognized obligation to:

8 (A) treat an insured whom the physician or
9 provider is currently treating; and

10 (B) cooperate in arranging for appropriate
11 referrals; or

12 (2) release the insurer from the obligation to
13 reimburse the physician or health care provider or, if applicable,
14 the insured, at the same preferred provider rate if, at the time a
15 physician's or provider's participation is terminated, an insured
16 whom the physician or provider is currently treating has special
17 circumstances in accordance with the dictates of medical prudence.

18 (c) The treating physician or health care provider shall
19 identify a special circumstance. The treating physician or health
20 care provider shall:

21 (1) request that the insured be permitted to continue
22 treatment under the physician's or provider's care; and

23 (2) agree not to seek payment from the insured of any
24 amount for which the insured would not be responsible if the
25 physician or provider were still a preferred provider. (V.T.I.C.
26 Art. 3.70-3C, Secs. 1(7), 4(b), (c), as added Acts 75th Leg., R.S.,
27 Ch. 1024.)

28 Source Law

29 [Sec. 1]

30 (7) "Life threatening" means a disease or
31 condition for which the likelihood of death is
32 probable unless the course of the disease or condition
33 is interrupted.

34 [Sec. 4]

35 (b) Each contract between an insurer and a
36 physician or health care provider must provide that
37 the termination of a preferred provider's
38 participation in the plan, except for reason of

1 medical competence or professional behavior, shall not
2 release the physician or health care provider from the
3 generally recognized obligation to treat the insured
4 and to cooperate in arranging for appropriate
5 referrals; nor does it release the insurer from the
6 obligation to reimburse the physician or health care
7 provider or, if applicable, the insured at the same
8 preferred provider rate if, at the time of the
9 preferred provider's termination, the insured has
10 special circumstances such as a disability, acute
11 condition, or life-threatening illness or is past the
12 24th week of pregnancy and is receiving treatment in
13 accordance with the dictates of medical prudence.

14 (c) For purposes of Subsection (b) of this
15 section, "special circumstances" means a condition
16 such that the treating physician or health care
17 provider reasonably believes that discontinuing care
18 by the treating physician or provider could cause harm
19 to the patient. Special circumstances shall be
20 identified by the treating physician or health care
21 provider, who must request that the insured be
22 permitted to continue treatment under the physician's
23 or provider's care and agree not to seek payment from
24 the patient of any amounts for which the insured would
25 not be responsible if the physician or provider were
26 still a preferred provider.

27 Revised Law

28 Sec. 1301.154. OBLIGATION FOR CONTINUITY OF CARE OF
29 INSURER. (a) Except as provided by Subsection (b), Sections
30 1301.152 and 1301.153 do not extend an insurer's obligation to
31 reimburse the terminated physician or provider or, if applicable,
32 the insured at the preferred provider level of coverage for ongoing
33 treatment of an insured after:

34 (1) the 90th day after the effective date of the
35 termination; or

36 (2) if the insured has been diagnosed as having a
37 terminal illness at the time of the termination, the expiration of
38 the nine-month period after the effective date of the termination.

39 (b) If an insured is past the 24th week of pregnancy at the
40 time of termination, an insurer's obligation to reimburse, at the
41 preferred provider level of coverage, the physician or provider or,
42 if applicable, the insured, extends through delivery of the child,
43 immediate postpartum care, and the follow-up checkup within the
44 six-week period after delivery. (V.T.I.C. Art. 3.70-3C, Sec. 4(e),
45 as added Acts 75th Leg., R.S., Ch. 1024.)

46 Source Law

47 (e) This section does not extend the obligation

1 of the insurer to reimburse, at the preferred provider
2 level of coverage, the terminated physician or health
3 care provider or, if applicable, the insured for
4 ongoing treatment of an insured after the 90th day from
5 the effective date of the termination, or beyond nine
6 months in the case of an enrollee who at the time of the
7 termination has been diagnosed with a terminal
8 illness. However, the obligation of the insurer to
9 reimburse, at the preferred provider level of
10 coverage, the terminated physician or health care
11 provider or, if applicable, the insured who at the time
12 of the termination is past the 24th week of pregnancy,
13 extends through delivery of the child, immediate
14 post-partum care, and the follow-up checkup within the
15 first six weeks of delivery.

16 Revised Law

17 Sec. 1301.155. EMERGENCY CARE. (a) In this section,
18 "emergency care" means health care services provided in a hospital
19 emergency facility or comparable facility to evaluate and stabilize
20 a medical condition of a recent onset and severity, including
21 severe pain, that would lead a prudent layperson possessing an
22 average knowledge of medicine and health to believe that the
23 person's condition, sickness, or injury is of such a nature that
24 failure to get immediate medical care could result in:

- 25 (1) placing the person's health in serious jeopardy;
26 (2) serious impairment to bodily functions;
27 (3) serious dysfunction of a bodily organ or part;
28 (4) serious disfigurement; or
29 (5) in the case of a pregnant woman, serious jeopardy
30 to the health of the fetus.

31 (b) If an insured cannot reasonably reach a preferred
32 provider, an insurer shall provide reimbursement for the following
33 emergency care services at the preferred level of benefits until
34 the insured can reasonably be expected to transfer to a preferred
35 provider:

36 (1) a medical screening examination or other
37 evaluation required by state or federal law to be provided in the
38 emergency facility of a hospital that is necessary to determine
39 whether a medical emergency condition exists;

40 (2) necessary emergency care services, including the
41 treatment and stabilization of an emergency medical condition; and

1 (3) services originating in a hospital emergency
2 facility following treatment or stabilization of an emergency
3 medical condition. (V.T.I.C. Art. 3.70-3C, Secs. 1(1), 5, as added
4 Acts 75th Leg., R.S., Ch. 1024.)

5 Source Law

6 Sec. 1. In this article:

7 (1) "Emergency care" means health care
8 services provided in a hospital emergency facility or
9 comparable facility to evaluate and stabilize medical
10 conditions of a recent onset and severity, including
11 but not limited to severe pain, that would lead a
12 prudent layperson possessing an average knowledge of
13 medicine and health to believe that the person's
14 condition, sickness, or injury is of such a nature that
15 failure to get immediate medical care could result in:

16 (A) placing the patient's health in
17 serious jeopardy;

18 (B) serious impairment to bodily
19 functions;

20 (C) serious dysfunction of any bodily
21 organ or part;

22 (D) serious disfigurement; or

23 (E) in the case of a pregnant woman,
24 serious jeopardy to the health of the fetus.

25 Sec. 5. If the insured cannot reasonably reach a
26 preferred provider, an insurer shall provide
27 reimbursement for the following emergency care
28 services at the preferred level of benefits until the
29 insured can reasonably be expected to transfer to a
30 preferred provider:

31 (1) any medical screening examination or
32 other evaluation required by state or federal law to be
33 provided in the emergency facility of a hospital which
34 is necessary to determine whether a medical emergency
35 condition exists;

36 (2) necessary emergency care services
37 including the treatment and stabilization of an
38 emergency medical condition; and

39 (3) services originating in a hospital
40 emergency facility following treatment or
41 stabilization of an emergency medical condition.

42 Revised Law

43 Sec. 1301.156. PAYMENT OF CLAIMS TO INSURED. An insurer
44 shall comply with Subchapter B, Chapter 542, with respect to prompt
45 payment to insureds. (V.T.I.C. Art. 3.70-3C, Sec. 3(m) (part), as
46 added Acts 75th Leg., R.S., Ch. 1024.)

47 Source Law

48 (m) An insurer shall comply with Article 21.55
49 of this code with respect to prompt payment of
50 insureds. . . .

51 Revised Law

52 Sec. 1301.157. PLAIN LANGUAGE REQUIREMENTS. Each health

1 insurance policy, health benefit plan certificate, endorsement,
2 amendment, application, or rider must:

- 3 (1) be written in plain language;
- 4 (2) be in a readable and understandable format; and
- 5 (3) comply with all applicable requirements relating
6 to minimum readability requirements. (V.T.I.C. Art. 3.70-3C, Sec.
7 6(a), as added Acts 75th Leg., R.S., Ch. 1024.)

8 Source Law

9 Sec. 6. (a) All health insurance policies,
10 health benefit plan certificates, endorsements,
11 amendments, applications, or riders shall be written
12 in plain language, must be in a readable and
13 understandable format, and must comply with all
14 applicable requirements relating to minimum
15 readability requirements.

16 Revised Law

17 Sec. 1301.158. INFORMATION CONCERNING PREFERRED PROVIDER
18 BENEFIT PLANS. (a) In this section, "prospective insured" means:

19 (1) for group coverage, an individual or an
20 individual's dependent who is eligible for coverage under a health
21 insurance policy issued to the group; or

22 (2) for individual coverage, an individual or an
23 individual's dependent who is eligible for coverage and who has
24 expressed an interest in purchasing an individual health insurance
25 policy.

26 (b) An insurer shall provide to a current or prospective
27 group contract holder or current or prospective insured on request
28 an accurate written description of the terms of the health
29 insurance policy to allow the current or prospective group contract
30 holder or current or prospective insured to make comparisons and an
31 informed decision before selecting among health care plans. The
32 description must be in a readable and understandable format as
33 prescribed by the commissioner and must include a current list of
34 preferred providers. The insurer may satisfy this requirement by
35 providing its handbook if:

36 (1) the handbook's content is substantively similar to
37 and achieves the same level of disclosure as the written

1 description prescribed by the commissioner; and

2 (2) the current list of preferred providers is
3 provided.

4 (c) An insurer or an agent or representative of an insurer
5 may not use or distribute, or permit the use or distribution of,
6 information for prospective insureds that is untrue or misleading.
7 (V.T.I.C. Art. 3.70-3C, Secs. 1(11), 6(b), (d), as added Acts 75th
8 Leg., R.S., Ch. 1024.)

9 Source Law

10 [Sec. 1]

11 (11) "Prospective insured" means:
12 (A) for group coverage, an
13 individual, including dependents, eligible for
14 coverage under a health insurance policy issued to the
15 group; or
16 (B) for individual coverage, an
17 individual, including dependents, eligible for
18 coverage who has expressed an interest in purchasing
19 an individual health insurance policy.

20 [Sec. 6]

21 (b) The insurer shall provide to a current or
22 prospective group contract holder or current or
23 prospective insured on request an accurate written
24 description of the terms and conditions of the policy
25 to allow the current or prospective group contract
26 holder or current or prospective insured to make
27 comparisons and informed decisions before selecting
28 among health care plans. The written description must
29 be in a readable and understandable format as
30 prescribed by the commissioner and must include a
31 current list of preferred providers. The insurer may
32 provide its handbook to satisfy this requirement
33 provided the handbook's content is substantively
34 similar to and achieves the same level of disclosure as
35 the written description prescribed by the commissioner
36 and the current list of physicians and health care
37 providers is provided.

38 (d) No insurer, or agent or representative of an
39 insurer, may cause or permit the use or distribution of
40 prospective insured information which is untrue or
41 misleading.

42 Revised Law

43 Sec. 1301.159. ANNUAL LIST OF PREFERRED PROVIDERS. A
44 current list of preferred providers shall be provided to each
45 insured at least annually. (V.T.I.C. Art. 3.70-3C, Sec. 6(c), as
46 added Acts 75th Leg., R.S., Ch. 1024.)

47 Source Law

48 (c) A current list of preferred providers shall
49 be provided to all insureds no less than annually.

1 Revised Law

2 Sec. 1301.160. NOTIFICATION OF TERMINATION OF
3 PARTICIPATION OF PREFERRED PROVIDER. (a) If a practitioner's
4 participation in a preferred provider benefit plan is terminated
5 for a reason other than at the practitioner's request, an insurer
6 may not notify insureds of the termination until the later of:

7 (1) the effective date of the termination; or

8 (2) the time at which a review panel makes a formal
9 recommendation regarding the termination.

10 (b) A physician or health care provider that voluntarily
11 terminates the physician's or provider's participation in a
12 preferred provider benefit plan shall provide reasonable notice to
13 each insured under the physician's or provider's care. The insurer
14 shall provide assistance to the physician or provider in ensuring
15 that the notice requirements of this subsection are met.

16 (c) If a practitioner's participation in a preferred
17 provider benefit plan is terminated for reasons related to imminent
18 harm, an insurer may notify insureds immediately. (V.T.I.C.
19 Art. 3.70-3C, Sec. 6(e), as added Acts 75th Leg., R.S., Ch. 1024.)

20 Source Law

21 (e)(1) If a physician or practitioner is
22 terminated for reasons other than at the preferred
23 provider's request, an insurer shall not notify
24 enrollees of the termination until the effective date
25 of the termination or at such time as a review panel
26 makes a formal recommendation regarding the
27 termination, whichever is later.

28 (2) If a physician or provider voluntarily
29 terminates the physician's or provider's relationship
30 with an insurer, the physician or provider shall
31 provide reasonable notice to enrollees under the
32 physician's or provider's care. The insurer shall
33 provide assistance to the physician or provider in
34 assuring that the notice requirements of this
35 subdivision are met.

36 (3) If a physician or practitioner is
37 terminated for reasons related to imminent harm, an
38 insurer may notify enrollees immediately.

39 Revisor's Note

40 Section 6(e), V.T.I.C. Article 3.70-3C, as added
41 by Chapter 1024, Acts of the 75th Legislature, Regular
42 Session, 1997, refers to an "enrollee" under a

1 preferred provider benefit plan. For consistency
2 throughout this chapter, the revised law substitutes
3 "insured" for "enrollee."

4 Revised Law

5 Sec. 1301.161. RETALIATION AGAINST INSURED PROHIBITED. An
6 insurer may not engage in any retaliatory action against an
7 insured, including canceling or refusing to renew a health
8 insurance policy, because the insured or a person acting on the
9 insured's behalf has:

10 (1) filed a complaint against the insurer or against a
11 preferred provider; or

12 (2) appealed a decision of the insurer. (V.T.I.C.
13 Art. 3.70-3C, Sec. 7(a), as added Acts 75th Leg., R.S., Ch. 1024.)

14 Source Law

15 Sec. 7. (a) No insurer shall engage in any
16 retaliatory action against an insured, including
17 cancellation of or refusal to renew a policy, because
18 the insured, or a person acting on behalf of the
19 insured, has filed a complaint against the insurer or
20 against a preferred provider or has appealed a
21 decision of the insurer.

22 [Sections 1301.162-1301.200 reserved for expansion]

23 SUBCHAPTER E. CERTAIN HEALTH CARE PROVIDERS

24 Revised Law

25 Sec. 1301.201. CONTRACTS WITH AND REIMBURSEMENT FOR NURSE
26 FIRST ASSISTANTS. A preferred provider may not refuse to:

27 (1) contract with a nurse first assistant, as defined
28 by Section 301.1525, Occupations Code, to be included in the
29 provider's network; or

30 (2) reimburse the nurse first assistant for a covered
31 service that a physician has requested the nurse first assistant to
32 perform. (V.T.I.C. Art. 3.70-3C, Sec. 3(o), as added Acts 75th
33 Leg., R.S., Ch. 1024.)

34 Source Law

35 (o) A preferred provider may not refuse to
36 contract with a nurse first assistant, as defined by
37 Section 301.1525, Occupations Code, to be included in
38 the provider's network or refuse to reimburse the nurse
39 first assistant for a covered service that a physician

1 has requested the nurse first assistant to perform.

2 [Chapters 1302-1350 reserved for expansion]

3 SUBTITLE E. BENEFITS PAYABLE UNDER HEALTH COVERAGES

4 CHAPTER 1351. HOME HEALTH SERVICES

5 Sec. 1351.001. DEFINITIONS 887

6 Sec. 1351.002. APPLICABILITY OF CHAPTER 888

7 Sec. 1351.003. APPLICABILITY OF GENERAL

8 PROVISIONS OF OTHER LAW 890

9 Sec. 1351.004. EXCEPTION. 891

10 Sec. 1351.005. COVERAGE REQUIRED 891

11 Sec. 1351.006. REIMBURSEMENT FOR HOME HEALTH SERVICES:

12 PHYSICIAN CERTIFICATION REQUIRED 892

13 Sec. 1351.007. LIMITATIONS AND EXCLUSIONS ON

14 COVERAGE PERMITTED 893

15 Sec. 1351.008. REJECTION OF COVERAGE BY PLAN HOLDER;

16 NEGOTIATION OF ALTERNATIVE COVERAGE 894

17 Sec. 1351.009. ADDITIONAL COVERAGE NOT PRECLUDED 895

18 CHAPTER 1351. HOME HEALTH SERVICES

19 Revised Law

20 Sec. 1351.001. DEFINITIONS. In this chapter:

21 (1) "Health services" includes:

22 (A) skilled nursing by a registered nurse or a
23 licensed vocational nurse under the supervision of at least one
24 registered nurse and at least one physician;

25 (B) physical, occupational, speech, or
26 respiratory therapy;

27 (C) the services of a home health aide under the
28 supervision of a registered nurse; and

29 (D) the furnishing of medical equipment and
30 supplies other than drugs or medicines.

31 (2) "Home health agency" means a business that:

32 (A) provides home health services; and

33 (B) is licensed by the Texas Department of Human
34 Services under Chapter 142, Health and Safety Code.

1 (3) "Home health services" means the provision of
2 health services for payment or other consideration in a patient's
3 residence under a plan of care that is:

4 (A) established, approved in writing, and
5 reviewed at least every two months by the attending physician; and

6 (B) certified by the attending physician as
7 necessary for medical purposes. (V.T.I.C. Art. 3.70-3B, Sec. 1.)

8 Source Law

9 Art. 3.70-3B

10 Sec. 1. As used in this article:

11 (1) "Health services" includes:

12 (A) skilled nursing by a registered
13 nurse or licensed vocational nurse under the
14 supervision of at least one registered nurse and at
15 least one physician;

16 (B) physical, occupational, speech,
17 or respiratory therapy;

18 (C) the service of a home health aide
19 under the supervision of a registered nurse; and

20 (D) the furnishing of medical
21 equipment and medical supplies other than drugs and
22 medicines.

23 (2) "Home health agency" means a business
24 that provides home health service and is licensed by
25 the Texas Department of Health under Chapter 142,
26 Health and Safety Code.

27 (3) "Home health service" means the
28 provision of a health service for payment or other
29 consideration in a patient's residence under a plan of
30 care established, approved in writing, and reviewed at
31 least every two months by the attending physician and
32 certified by the attending physician as necessary for
33 medical purposes.

34 Revisor's Note

35 Section 1, V.T.I.C. Article 3.70-3B, refers to a
36 home health agency that is "licensed by the Texas
37 Department of Health under Chapter 142, Health and
38 Safety Code." Under Section 1.24, Chapter 1505, Acts
39 of the 76th Legislature, Regular Session, 1999,
40 responsibility for licensing agencies under Chapter
41 142 was transferred from the Texas Department of
42 Health to the Texas Department of Human Services. The
43 revised law is drafted accordingly.

44 Revised Law

45 Sec. 1351.002. APPLICABILITY OF CHAPTER. (a) This
46 chapter applies to a group health benefit plan that is delivered or

1 issued for delivery in this state and that is a group policy of
2 accident and health insurance, including a policy issued by a group
3 hospital service corporation operating under Chapter 842.

4 (b) This chapter applies to an accident and health insurance
5 policy issued by a stipulated premium company subject to Chapter
6 884. (V.T.I.C. Art. 3.70-3B, Sec. 2(a) (part); Art. 3.70-8, Secs.
7 (a) (part), (b).)

8 Source Law

9 [Art. 3.70-3B]

10 Sec. 2. (a) . . . a group policy of accident
11 and sickness insurance, including policies issued by
12 companies subject to Chapter 20 of this code, may not
13 be delivered or issued for delivery to any person in
14 this state [unless benefits for home health service
15 provided by a licensed home health agency are included
16 in that group policy.] . . .

17 Art. 3.70-8. [(a) Nothing in this Act shall
18 apply to . . . any blanket or group policy of insurance
19 except as provided] . . . in article 3.70-3B

20 (b) This Act applies to a health, accident,
21 sickness, and hospitalization policy issued by a
22 stipulated premium insurer subject to Chapter 884 of
23 this code.

24 Revisor's Note

25 (1) Section 2(a), V.T.I.C. Article 3.70-3B,
26 refers to a group policy of "accident and sickness
27 insurance." Similarly, Sections (a) and (b), V.T.I.C.
28 Article 3.70-8, refer to a "blanket or group policy of
29 insurance," meaning a policy of accident and sickness
30 insurance described by Section (B), V.T.I.C. Article
31 3.70-2, and to a "health, accident, sickness, and
32 hospitalization policy," respectively. For
33 consistency with modern usage, the revised law
34 substitutes "accident and health" for "accident and
35 sickness" and for "health, accident, sickness, and
36 hospitalization." Comparable changes necessary to
37 ensure consistent use of terminology have been made
38 throughout this chapter.

39 (2) Section 2(a), V.T.I.C. Article 3.70-3B,
40 refers to "policies issued by companies" subject to

1 V.T.I.C. Chapter 20, revised as Chapter 842 of this
2 code. The term most frequently used to refer to such a
3 company is "group hospital service corporation."
4 Consequently, the revised law substitutes "group
5 hospital service corporation" for "companies" to
6 provide for consistent use of terminology throughout
7 this code.

8 Revised Law

9 Sec. 1351.003. APPLICABILITY OF GENERAL PROVISIONS OF OTHER
10 LAW. The provisions of Chapter 1201, including provisions
11 relating to the applicability, purpose, and enforcement of that
12 chapter, the construction of policies under that chapter,
13 rulemaking under that chapter, and definitions of terms applicable
14 in that chapter, apply to this chapter. (New.)

15 Revisor's Note

16 Chapter 397, Acts of the 54th Legislature,
17 Regular Session, 1955, published as V.T.I.C. Articles
18 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4,
19 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and
20 3.70-11, contains general provisions applicable to
21 V.T.I.C. Article 3.70-3B, revised as this chapter. It
22 is clear that the legislature intended the general
23 provisions of Chapter 397 to apply to Article 3.70-3B
24 because when the legislature enacted Article 3.70-3B,
25 it also amended V.T.I.C. Article 3.70-8, a
26 nonapplicability provision derived from Chapter 397,
27 to provide an exception for Article 3.70-3B. The
28 majority of the articles derived from Chapter 397 are
29 revised in this code as Chapter 1201. Section 1351.003
30 is added to indicate the applicability of the general
31 provisions of those articles to this chapter. For the
32 convenience of the reader, the revised law includes
33 general descriptions of some of the applicable
34 provisions of Chapter 1201.

1 Revised Law

2 Sec. 1351.004. EXCEPTION. This chapter does not apply to:

3 (1) a group policy of accident and health insurance
4 that provides coverage only for:

5 (A) a specified disease or diseases;

6 (B) vision care;

7 (C) dental care;

8 (D) hospital indemnity;

9 (E) prescription drugs; or

10 (F) other limited benefits;

11 (2) a blanket insurance policy, as described by
12 Chapter 1251;

13 (3) a short-term travel insurance policy;

14 (4) an accident-only insurance policy;

15 (5) a hospital indemnity insurance policy;

16 (6) a limited or specified disease insurance policy;

17 (7) an insurance policy or contract issued under a
18 right of conversion; or

19 (8) an insurance policy or contract designed for
20 issuance to a person eligible for Medicare coverage. (V.T.I.C.
21 Art. 3.70-3B, Sec. 2(c).)

22 Source Law

23 (c) This article does not apply to:

24 (1) group accident and sickness policies
25 that provide only coverage for a specified disease or
26 diseases, vision care, dental care, hospital
27 indemnity, prescription drugs, or other limited
28 benefits;

29 (2) blanket insurance policies, as defined
30 in Article 3.51-6, Insurance Code;

31 (3) short-term travel insurance;

32 (4) accident-only insurance;

33 (5) hospital indemnity policies;

34 (6) limited or specified disease policies;

35 (7) insurance policies or contracts issued
36 pursuant to a right of conversion; or

37 (8) insurance policies or contracts
38 designed for issuance to persons eligible for
39 Medicare.

40 Revised Law

41 Sec. 1351.005. COVERAGE REQUIRED. Except as provided by
42 Section 1351.008, a group health benefit plan must provide coverage

1 for home health services provided by a home health agency.
2 (V.T.I.C. Art. 3.70-3B, Sec. 2(a) (part).)

3 Source Law

4 Sec. 2. (a) Except as provided by Subsections
5 (b) and (c) of this section, [a group policy of
6 accident and sickness insurance, including policies
7 issued by companies subject to Chapter 20 of this code,
8 may not be delivered or issued for delivery to any
9 person in this state] unless benefits for home health
10 service provided by a licensed home health agency are
11 included in that group policy. . . .

12 Revisor's Note

13 (1) Section 2(a), V.T.I.C. Article 3.70-3B,
14 prohibits the delivery or issuance of certain group
15 policies "[e]xcept as provided by Subsections . . .
16 (c) of this section." Section 2(c), V.T.I.C. Article
17 3.70-3B, revised as Section 1351.004, specifies the
18 types of coverage exempt from the application of
19 V.T.I.C. Article 3.70-3B, revised as this chapter.
20 The revised law omits "[e]xcept as provided by
21 Subsections . . . (c) of this section" as unnecessary
22 because if a policy is exempt under Section 2(c), then
23 the policy is not subject to the prohibition stated in
24 Section 2(a).

25 (2) Section 2(a), V.T.I.C. Article 3.70-3B,
26 refers to a "licensed home health agency." The revised
27 law omits "licensed" as unnecessary because "home
28 health agency" is defined by Section 1(2) of that
29 article, revised as Section 1351.001(2), to mean a
30 business that is licensed by the Texas Department of
31 Human Services.

32 Revised Law

33 Sec. 1351.006. REIMBURSEMENT FOR HOME HEALTH SERVICES:
34 PHYSICIAN CERTIFICATION REQUIRED. A group health benefit plan
35 issuer may not provide reimbursement for home health services
36 provided under the plan unless the attending physician certifies
37 that hospitalization or confinement in a skilled facility would be

1 required if a treatment plan for home health care were not provided.
2 (V.T.I.C. Art. 3.70-3B, Sec. 2(a) (part).)

3 Source Law

4 (a) . . . Home health services provided under
5 this section may not be reimbursed unless the
6 attending physician certifies that hospitalization or
7 confinement in a skilled facility would otherwise be
8 required if a treatment plan for home health care was
9 not provided.

10 Revised Law

11 Sec. 1351.007. LIMITATIONS AND EXCLUSIONS ON COVERAGE
12 PERMITTED. (a) A group health benefit plan may include:

13 (1) a limitation on the number of visits for home
14 health services for which benefits are payable, subject to
15 Subsection (b);

16 (2) an exclusion for home health services coverage
17 for:

18 (A) custodial care;

19 (B) services provided by an individual who:

20 (i) resides in the covered individual's
21 home; or

22 (ii) is a member of the covered individual's
23 family; or

24 (C) services provided to a covered individual who
25 is eligible for Medicare coverage;

26 (3) annual deductible and coinsurance provisions for
27 home health services coverage that are not less favorable than the
28 deductible or coinsurance provisions applicable to hospital
29 services coverage under the plan; and

30 (4) other coverage limitations or exclusions
31 consistent with the remaining provisions of the plan.

32 (b) A limitation under Subsection (a)(1) may not limit each
33 individual covered under the plan to fewer than 60 visits in any
34 calendar year or continuous 12-month period.

35 (c) For purposes of this section, each of the following is
36 considered to be one visit for home health services:

1 (1) a visit by a representative of a home health
2 agency;

3 (2) four hours of home health aide service; and

4 (3) if home health aide service extends beyond four
5 hours, each additional four hours or portion of that four-hour
6 period. (V.T.I.C. Art. 3.70-3B, Secs. 3(a), (b), (c).)

7 Source Law

8 Sec. 3. (a) A policy of accident or sickness
9 insurance issued under Subsection (a) of Section 2 of
10 this article may include:

11 (1) a limitation on the number of home
12 health care visits for which benefits are payable,
13 provided the number of visits for which benefits are
14 payable may not be fewer than 60 visits in any calendar
15 year or in any continuous period of 12 months for each
16 person covered under the policy or contract;

17 (2) annual deductible and coinsurance
18 provisions provided that those provisions are not less
19 favorable than the deductible or coinsurance
20 provisions applicable to covered hospital services
21 under the policy; and

22 (3) an exclusion for home health benefits
23 for custodial care, for services provided by a person
24 who resides in the covered person's home or is a member
25 of the covered person's family, or for services
26 provided to a covered person who is eligible for
27 Medicare.

28 (b) For the purposes of Subdivision (1) of
29 Subsection (a) of this section, each visit by a
30 representative of a home health agency is considered
31 as one home health care visit, four hours of home
32 health aide service is considered as one home health
33 care visit, and if service extends beyond four hours,
34 each four hours or portion of that period is considered
35 as one home health care visit.

36 (c) Home health benefits may be subject to
37 limitations and exclusions consistent with the balance
38 of the policy or contract.

39 Revised Law

40 Sec. 1351.008. REJECTION OF COVERAGE BY PLAN HOLDER;
41 NEGOTIATION OF ALTERNATIVE COVERAGE. (a) If the holder of a group
42 health benefit plan rejects in writing the coverage required under
43 this chapter, the plan issuer:

44 (1) may not include the coverage in the plan; and

45 (2) is not required to:

46 (A) offer the coverage to the plan holder; or

47 (B) provide the coverage under the plan.

48 (b) If a plan holder rejects in writing the coverage
49 required under this chapter, the plan holder and the plan issuer may

1 negotiate coverage for home health services other than the coverage
2 required under this chapter. (V.T.I.C. Art. 3.70-3B, Sec. 2(b).)

3 Source Law

4 (b) An insurer may not include the coverage
5 required by Subsection (a) of this section if the
6 policyholder rejects the coverage in writing. If a
7 policyholder rejects the coverage in writing as
8 provided by this subsection, the insurer has no
9 further obligation to offer or to provide coverage for
10 services under this article, provided that nothing
11 contained herein shall prevent the policyholder and
12 insurer from negotiating other benefits for home
13 health services following policyholder rejection as
14 provided above.

15 Revised Law

16 Sec. 1351.009. ADDITIONAL COVERAGE NOT PRECLUDED. This
17 chapter does not preclude a group health benefit plan issuer from
18 providing coverage for home health services that exceeds the
19 coverage required under this chapter. (V.T.I.C. Art. 3.70-3B, Sec.
20 3(d).)

21 Source Law

22 (d) This article does not preclude a group
23 policy of accident and sickness insurance, including
24 policies issued by companies licensed pursuant to
25 Chapter 20 of this code, from including home health
26 services in excess of those provided in this article.

27 CHAPTER 1352. BRAIN INJURY

28	Sec. 1352.001. APPLICABILITY OF CHAPTER	895
29	Sec. 1352.002. EXCEPTION.	897
30	Sec. 1352.003. EXCLUSION OF COVERAGE PROHIBITED	898
31	Sec. 1352.004. TRAINING FOR CERTAIN PERSONNEL REQUIRED . . .	899

32 CHAPTER 1352. BRAIN INJURY

33 Revised Law

34 Sec. 1352.001. APPLICABILITY OF CHAPTER. This chapter
35 applies only to a health benefit plan, including a small employer
36 health benefit plan written under Chapter 1501, that provides
37 benefits for medical or surgical expenses incurred as a result of a
38 health condition, accident, or sickness, including an individual,
39 group, blanket, or franchise insurance policy or insurance
40 agreement, a group hospital service contract, or an individual or
41 group evidence of coverage or similar coverage document that is

1 offered by:

2 (1) an insurance company;

3 (2) a group hospital service corporation operating
4 under Chapter 842;

5 (3) a fraternal benefit society operating under
6 Chapter 885;

7 (4) a stipulated premium company operating under
8 Chapter 884;

9 (5) a reciprocal exchange operating under Chapter 942;

10 (6) a Lloyd's plan operating under Chapter 941;

11 (7) a health maintenance organization operating under
12 Chapter 843;

13 (8) a multiple employer welfare arrangement that holds
14 a certificate of authority under Chapter 846; or

15 (9) an approved nonprofit health corporation that
16 holds a certificate of authority under Chapter 844. (V.T.I.C.
17 Art. 21.53Q, Secs. 1(a), (b).)

18 Source Law

19 Art. 21.53Q

20 Sec. 1. (a) This article applies only to a
21 health benefit plan that provides benefits for medical
22 or surgical expenses incurred as a result of a health
23 condition, accident, or sickness, including an
24 individual, group, blanket, or franchise insurance
25 policy or insurance agreement, a group hospital
26 service contract, or an individual or group evidence
27 of coverage or similar coverage document that is
28 offered by:

29 (1) an insurance company;

30 (2) a group hospital service corporation
31 operating under Chapter 20 of this code;

32 (3) a fraternal benefit society operating
33 under Chapter 10 of this code;

34 (4) a stipulated premium insurance company
35 operating under Chapter 22 of this code;

36 (5) a reciprocal exchange operating under
37 Chapter 19 of this code;

38 (6) a Lloyd's plan operating under Chapter
39 18 of this code;

40 (7) a health maintenance organization
41 operating under the Texas Health Maintenance
42 Organization Act (Chapter 20A, Vernon's Texas
43 Insurance Code);

44 (8) a multiple employer welfare
45 arrangement that holds a certificate of authority
46 under Article 3.95-2 of this code; or

47 (9) an approved nonprofit health
48 corporation that holds a certificate of authority
49 under Article 21.52F of this code.

1 (b) This article applies to a small employer
2 health benefit plan written under Chapter 26 of this
3 code.

4 Revised Law

5 Sec. 1352.002. EXCEPTION. This chapter does not apply to:

6 (1) a plan that provides coverage:

7 (A) only for a specified disease or for another
8 limited benefit other than an accident policy;

9 (B) only for accidental death or dismemberment;

10 (C) for wages or payments in lieu of wages for a
11 period during which an employee is absent from work because of
12 sickness or injury;

13 (D) as a supplement to a liability insurance
14 policy;

15 (E) for credit insurance;

16 (F) only for dental or vision care;

17 (G) only for hospital expenses; or

18 (H) only for indemnity for hospital confinement;

19 (2) a Medicare supplemental policy as defined by
20 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),
21 as amended;

22 (3) a workers' compensation insurance policy;

23 (4) medical payment insurance coverage provided under
24 a motor vehicle insurance policy; or

25 (5) a long-term care insurance policy, including a
26 nursing home fixed indemnity policy, unless the commissioner
27 determines that the policy provides benefit coverage so
28 comprehensive that the policy is a health benefit plan as described
29 by Section 1352.001. (V.T.I.C. Art. 21.53Q, Sec. 1(c).)

30 Source Law

31 (c) This article does not apply to:

32 (1) a plan that provides coverage:

33 (A) only for benefits for a specified
34 disease or for another limited benefit other than an
35 accident policy;

36 (B) only for accidental death or
37 dismemberment;

38 (C) for wages or payments in lieu of
39 wages for a period during which an employee is absent
40 from work because of sickness or injury;

1 (D) as a supplement to a liability
2 insurance policy;
3 (E) for credit insurance;
4 (F) only for dental or vision care;
5 (G) only for hospital expenses; or
6 (H) only for indemnity for hospital
7 confinement;
8 (2) a Medicare supplemental policy as
9 defined by Section 1882(g)(1), Social Security Act (42
10 U.S.C. Section 1395ss), as amended;
11 (3) a workers' compensation insurance
12 policy;
13 (4) medical payment insurance coverage
14 provided under a motor vehicle insurance policy; or
15 (5) a long-term care insurance policy,
16 including a nursing home fixed indemnity policy,
17 unless the commissioner determines that the policy
18 provides benefit coverage so comprehensive that the
19 policy is a health benefit plan as described by
20 Subsection (a) of this section.

21 Revised Law

22 Sec. 1352.003. EXCLUSION OF COVERAGE PROHIBITED. (a) A
23 health benefit plan may not exclude coverage for cognitive
24 rehabilitation therapy, cognitive communication therapy,
25 neurocognitive therapy and rehabilitation, neurobehavioral,
26 neurophysiological, neuropsychological, or psychophysiological
27 testing or treatment, neurofeedback therapy, remediation,
28 post-acute transition services, or community reintegration
29 services necessary as a result of and related to an acquired brain
30 injury.

31 (b) Coverage required under this chapter may be subject to
32 deductibles, copayments, coinsurance, or annual or maximum payment
33 limits that are consistent with the deductibles, copayments,
34 coinsurance, or annual or maximum payment limits applicable to
35 other similar coverage provided under the health benefit plan.

36 (c) The commissioner shall adopt rules as necessary to
37 implement this section. (V.T.I.C. Art. 21.53Q, Sec. 2.)

38 Source Law

39 Sec. 2. (a) A health benefit plan may not
40 exclude coverage for cognitive rehabilitation
41 therapy, cognitive communication therapy,
42 neurocognitive therapy and rehabilitation,
43 neurobehavioral, neurophysiological,
44 neuropsychological, and psychophysiological testing
45 or treatment, neurofeedback therapy, remediation,
46 post-acute transition services, or community
47 reintegration services necessary as a result of and
48 related to an acquired brain injury.

49 (b) Coverage required under this article may be

1 subject to deductibles, copayments, coinsurance, or
2 annual or maximum payment limits that are consistent
3 with deductibles, copayments, coinsurance, and annual
4 or maximum payment limits applicable to other similar
5 coverage under the plan.

6 (c) The commissioner shall adopt rules as
7 necessary to implement this section.

8 Revised Law

9 Sec. 1352.004. TRAINING FOR CERTAIN PERSONNEL
10 REQUIRED. (a) In this section, "preauthorization" means the
11 provision of a reliable representation to a physician or health
12 care provider of whether a health benefit plan issuer will pay the
13 physician or provider for proposed medical or health care services
14 if the physician or provider provides those services to the patient
15 for whom the services are proposed. The term includes
16 precertification, certification, recertification, or any other
17 activity that involves providing a reliable representation by the
18 issuer to a physician or health care provider.

19 (b) The commissioner by rule shall require a health benefit
20 plan issuer to provide adequate training to personnel responsible
21 for preauthorization of coverage or utilization review under the
22 plan. The purpose of the training is to prevent denial of coverage
23 in violation of Section 1352.003 and to avoid confusion of medical
24 benefits with mental health benefits. (V.T.I.C. Art. 21.53Q, Sec.
25 3.)

26 Source Law

27 Sec. 3. (a) In this section, "preauthorization"
28 means the provision of a reliable representation to a
29 physician or health care provider of whether the
30 issuer of a health benefit plan will pay the physician
31 or provider for proposed medical or health care
32 services if the physician or provider renders those
33 services to the patient for whom the services are
34 proposed. The term includes precertification,
35 certification, recertification, or any other activity
36 that involves providing a reliable representation by
37 the issuer of a health benefit plan to a physician or
38 health care provider.

39 (b) The commissioner by rule shall require the
40 issuer of a health benefit plan to provide adequate
41 training to personnel responsible for
42 preauthorization of coverage or utilization review
43 under the plan to prevent wrongful denial of coverage
44 required under this article and to avoid confusion of
45 medical benefits with mental health benefits.

1 CHAPTER 1353. IMMUNIZATION OR VACCINATION

2 PROTOCOLS UNDER MANAGED CARE PLANS

3 Sec. 1353.001. PROHIBITED CONDUCT 900

4 Sec. 1353.002. RULES 900

5 CHAPTER 1353. IMMUNIZATION OR VACCINATION PROTOCOLS

6 UNDER MANAGED CARE PLANS

7 Revised Law

8 Sec. 1353.001. PROHIBITED CONDUCT. A managed care entity

9 may not:

10 (1) require a physician participating in a managed

11 care plan to issue an immunization or vaccination protocol for an

12 immunization or vaccination to be administered to an enrollee in

13 the plan;

14 (2) limit an enrollee's benefits for immunizations or

15 vaccinations to circumstances in which an immunization or

16 vaccination protocol is issued;

17 (3) provide a financial incentive to a physician to

18 issue an immunization or vaccination protocol; or

19 (4) impose a financial or other penalty on a physician

20 who refuses to issue an immunization or vaccination protocol.

21 (V.T.I.C. Art. 21.53K, Sec. 1.)

22 Source Law

23 Art. 21.53K

24 Sec. 1. (a) A managed care entity may not

25 require a physician participating in a managed care

26 plan to issue an immunization or vaccination protocol

27 for an immunization or vaccination to be administered

28 to an enrollee in the plan.

29 (b) This section prohibits a managed care entity

30 from:

31 (1) limiting benefits to enrollees for

32 immunizations or vaccinations to circumstances in

33 which an immunization or vaccination protocol is

34 issued;

35 (2) providing financial incentives to

36 physicians to issue an immunization or vaccination

37 protocol; or

38 (3) imposing a financial or other penalty

39 on a physician who refuses to issue an immunization or

40 vaccination protocol.

41 Revised Law

42 Sec. 1353.002. RULES. The commissioner may adopt rules to

1 implement this chapter. (V.T.I.C. Art. 21.53K, Sec. 2.)

2 Source Law

3 Sec. 2. The commissioner may adopt rules to
4 implement this article.

5 CHAPTER 1354. ELIGIBILITY FOR BENEFITS
6 FOR ALZHEIMER'S DISEASE

7 Sec. 1354.001. APPLICABILITY OF CHAPTER 901

8 Sec. 1354.002. PROOF OF ORGANIC DISEASE 901

9 CHAPTER 1354. ELIGIBILITY FOR BENEFITS
10 FOR ALZHEIMER'S DISEASE

11 Revised Law

12 Sec. 1354.001. APPLICABILITY OF CHAPTER. This chapter
13 applies only to a health benefit plan that:

- 14 (1) provides coverage for Alzheimer's disease; and
- 15 (2) is an individual or group policy, contract,
16 certificate, or evidence of coverage that is delivered or issued
17 for delivery in this state by an insurer or a group hospital service
18 corporation operating under Chapter 842. (V.T.I.C. Art. 3.78
19 (part).)

20 Source Law

21 Art. 3.78. [If] an individual or group policy,
22 contract, or certificate, or evidence of coverage
23 providing coverage for Alzheimer's disease is
24 delivered or issued for delivery in this state by an
25 insurer, including a group hospital service
26 corporation under Chapter 20 of this code, and

27 Revised Law

28 Sec. 1354.002. PROOF OF ORGANIC DISEASE. If a health
29 benefit plan requires demonstrable proof of organic disease or
30 other proof before the health benefit plan issuer will authorize
31 payment of benefits for Alzheimer's disease, that proof requirement
32 is satisfied by a clinical diagnosis of Alzheimer's disease made by
33 a physician licensed in this state, including a history and
34 physical, neurological, and psychological or psychiatric
35 evaluations, and laboratory studies. (V.T.I.C. Art. 3.78 (part).)

36 Source Law

37 Art. 3.78. If [an individual or group policy,

1 contract, or certificate, or evidence of coverage
 2 providing coverage for Alzheimer's disease is
 3 delivered or issued for delivery in this state by an
 4 insurer, including a group hospital service
 5 corporation under Chapter 20 of this code, and] the
 6 policy, contract, certificate, or evidence requires
 7 demonstrable proof of organic disease or other proof
 8 before the insurer will authorize payment of benefits
 9 for Alzheimer's disease, a clinical diagnosis of
 10 Alzheimer's disease by a physician licensed in this
 11 state, including history and physical, neurological,
 12 psychological and/or psychiatric evaluations, and
 13 laboratory studies, shall satisfy the requirement for
 14 demonstrable proof of organic disease or other proof
 15 under the coverage.

16 CHAPTER 1355. BENEFITS FOR CERTAIN MENTAL DISORDERS

17 SUBCHAPTER A. GROUP HEALTH BENEFIT PLAN

18 COVERAGE FOR CERTAIN SERIOUS MENTAL ILLNESSES

19 Sec. 1355.001. DEFINITIONS 903
 20 Sec. 1355.002. APPLICABILITY OF SUBCHAPTER 905
 21 Sec. 1355.003. EXCEPTION. 906
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 27 MARIHUANA NOT REQUIRED 909
 28 Sec. 1355.007. SMALL EMPLOYER COVERAGE. 909

29 [Sections 1355.008-1355.050 reserved for expansion]

30 SUBCHAPTER B. ALTERNATIVE MENTAL HEALTH TREATMENT BENEFITS

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8 Sec. 1355.103. APPLICABILITY OF GENERAL PROVISIONS

9 OF OTHER LAW 918

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11 PSYCHIATRIC DAY TREATMENT FACILITY 919

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13 PSYCHIATRIC DAY TREATMENT FACILITY 920

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15 BENEFITS 920

16 [Sections 1355.107-1355.150 reserved for expansion]

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18 Sec. 1355.151. PROHIBITION ON EXCLUSION OR LIMITATION

19 OF CERTAIN COVERAGES 921

20 [Sections 1355.152-1355.200 reserved for expansion]

21 SUBCHAPTER E. BENEFITS FOR TREATMENT BY

22 TAX-SUPPORTED INSTITUTION

23 Sec. 1355.201. APPLICABILITY OF GENERAL PROVISIONS OF

24 OTHER LAW 922

25 Sec. 1355.202. PROHIBITION OF EXCLUSION OF MENTAL HEALTH

26 OR MENTAL RETARDATION BENEFITS FOR

27 TREATMENT BY TAX-SUPPORTED INSTITUTION . . . 923

28 CHAPTER 1355. BENEFITS FOR CERTAIN MENTAL DISORDERS

29 SUBCHAPTER A. GROUP HEALTH BENEFIT PLAN COVERAGE

30 FOR CERTAIN SERIOUS MENTAL ILLNESSES

31 Revised Law

32 Sec. 1355.001. DEFINITIONS. In this subchapter:

33 (1) "Serious mental illness" means the following

34 psychiatric illnesses as defined by the American Psychiatric

1 Association in the Diagnostic and Statistical Manual (DSM):

2 (A) bipolar disorders (hypomanic, manic,
3 depressive, and mixed);

4 (B) depression in childhood and adolescence;

5 (C) major depressive disorders (single episode
6 or recurrent);

7 (D) obsessive-compulsive disorders;

8 (E) paranoid and other psychotic disorders;

9 (F) pervasive developmental disorders;

10 (G) schizo-affective disorders (bipolar or
11 depressive); and

12 (H) schizophrenia.

13 (2) "Small employer" has the meaning assigned by
14 Section 1501.002. (V.T.I.C. Art. 3.51-14, Secs. 1(1), (3).)

15 Source Law

16 Art. 3.51-14

17 Sec. 1. For purposes of this article:

18 (1) "Serious mental illness" means the
19 following psychiatric illnesses as defined by the
20 American Psychiatric Association in the Diagnostic and
21 Statistical Manual (DSM):

22 (A) schizophrenia;

23 (B) paranoid and other psychotic
24 disorders;

25 (C) bipolar disorders (hypomanic,
26 manic, depressive, and mixed);

27 (D) major depressive disorders
28 (single episode or recurrent);

29 (E) schizo-affective disorders
30 (bipolar or depressive);

31 (F) pervasive developmental
32 disorders;

33 (G) obsessive-compulsive disorders;
34 and

35 (H) depression in childhood and
36 adolescence.

37 (3) "Small employer" has the meaning
38 assigned by Article 26.02 of this code.

39 Revisor's Note

40 Section 1(2), V.T.I.C. Article 3.51-14, defines
41 "group health benefit plan." The revised law omits the
42 definition as unnecessary because Section 2 of that
43 article, revised as Sections 1355.002 and 1355.003,
44 specifies the types of group health benefit plans to

1 which this subchapter applies, and thus the defined
2 term is not helpful to the reader. The omitted law
3 reads:

4 (2) "Group health benefit plan"
5 means a plan described by Section 2 of this
6 article.

7 Revised Law

8 Sec. 1355.002. APPLICABILITY OF SUBCHAPTER. This
9 subchapter applies only to a group health benefit plan that
10 provides benefits for medical or surgical expenses incurred as a
11 result of a health condition, accident, or sickness, including:

12 (1) a group insurance policy, group insurance
13 agreement, group hospital service contract, or group evidence of
14 coverage that is offered by:

15 (A) an insurance company;

16 (B) a group hospital service corporation
17 operating under Chapter 842;

18 (C) a fraternal benefit society operating under
19 Chapter 885;

20 (D) a stipulated premium company operating under
21 Chapter 884; or

22 (E) a health maintenance organization operating
23 under Chapter 843; and

24 (2) to the extent permitted by the Employee Retirement
25 Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a plan
26 offered under:

27 (A) a multiple employer welfare arrangement as
28 defined by Section 3 of that Act; or

29 (B) another analogous benefit arrangement.
30 (V.T.I.C. Art. 3.51-14, Sec. 2(a).)

31 Source Law

32 Sec. 2. (a) This article applies only to a
33 group health benefit plan that provides benefits for
34 medical or surgical expenses incurred as a result of a
35 health condition, accident, or sickness, including:

36 (1) a group insurance policy or insurance
37 agreement, a group hospital service contract, or a
38 group evidence of coverage that is offered by:

1 (A) an insurance company;
2 (B) a group hospital service
3 corporation operating under Chapter 20 of this code;
4 (C) a health maintenance
5 organization operating under the Texas Health
6 Maintenance Organization Act (Chapter 20A, Vernon's
7 Texas Insurance Code);
8 (D) a fraternal benefit society
9 operating under Chapter 10 of this code; or
10 (E) a stipulated premium insurance
11 company operating under Chapter 22 of this code; and
12 (2) to the extent permitted by the
13 Employee Retirement Income Security Act of 1974 (29
14 U.S.C. Section 1001 et seq.), a group health benefit
15 plan that is offered under:
16 (A) a multiple employer welfare
17 arrangement as defined by Section 3, Employee
18 Retirement Income Security Act of 1974 (29 U.S.C.
19 Section 1002); or
20 (B) another analogous benefit
21 arrangement.

22 Revised Law

23 Sec. 1355.003. EXCEPTION. (a) This subchapter does not
24 apply to coverage under:

25 (1) a blanket accident and health insurance policy, as
26 described by Chapter 1251;

27 (2) a short-term travel policy;

28 (3) an accident-only policy;

29 (4) a limited or specified-disease policy that does
30 not provide benefits for mental health care or similar services;

31 (5) except as provided by Subsection (b), a plan
32 offered under Chapter 1551 or Chapter 1601;

33 (6) a plan offered in accordance with Section
34 1355.151; or

35 (7) a Medicare supplement benefit plan, as defined by
36 Section 1652.002.

37 (b) For the purposes of a plan described by Subsection
38 (a)(5), "serious mental illness" has the meaning assigned by
39 Section 1355.001. (V.T.I.C. Art. 3.51-14, Sec. 2(b).)

40 Source Law

41 (b) This article does not apply to coverage
42 under:

43 (1) a blanket accident and health
44 insurance policy as that term is defined under Section
45 2, Article 3.51-6, of this code;

46 (2) a short-term travel policy;

47 (3) an accident-only policy;

48 (4) a limited or specified-disease policy,

1 other than a plan that provides benefits for mental
2 health care or similar services;

3 (5) with the exception of Section 1 of this
4 article which shall apply, a plan offered under the
5 Texas Employees Uniform Group Insurance Benefits Act
6 (Article 3.50-2, Vernon's Texas Insurance Code) or the
7 Texas State College and University Employees Uniform
8 Insurance Benefits Act (Article 3.50-3, Vernon's Texas
9 Insurance Code);

10 (6) a plan offered under or in accordance
11 with Article 3.51-5A of this code; or

12 (7) a Medicare supplement policy, as that
13 term is defined under Section 1(b)(3), Article 3.74,
14 of this code.

15 Revisor's Note

16 (1) Section 2(b)(5), V.T.I.C. Article 3.51-14,
17 provides that "Section 1 of this article . . . shall
18 apply" to a plan offered under V.T.I.C. Article 3.50-2
19 or 3.50-3, revised as Chapters 1551 and 1601 of this
20 code. The clear purpose of the quoted language is to
21 preserve the definition of "serious mental illness"
22 for the purposes of those plans. The term "small
23 employer" is not used in Chapter 1551 or 1601, and the
24 definition of "group health benefit plan" is not
25 applicable in those chapters. The revised law is
26 drafted accordingly.

27 (2) Section 2(b)(7), V.T.I.C. Article 3.51-14,
28 refers to "a Medicare supplement policy, as that term
29 is defined under Section 1(b)(3), Article 3.74, of
30 this code." The revised law substitutes "Medicare
31 supplement benefit plan" because that is the term used
32 in Section 1652.002, which revises Section 1(b)(3),
33 V.T.I.C. Article 3.74.

34 Revised Law

35 Sec. 1355.004. REQUIRED COVERAGE FOR SERIOUS MENTAL
36 ILLNESS. (a) A group health benefit plan:

37 (1) must provide coverage, based on medical necessity,
38 for not less than the following treatments of serious mental
39 illness in each calendar year:

40 (A) 45 days of inpatient treatment; and

41 (B) 60 visits for outpatient treatment,

1 including group and individual outpatient treatment;

2 (2) may not include a lifetime limitation on the
3 number of days of inpatient treatment or the number of visits for
4 outpatient treatment covered under the plan; and

5 (3) must include the same amount limitations,
6 deductibles, copayments, and coinsurance factors for serious
7 mental illness as the plan includes for physical illness.

8 (b) A group health benefit plan issuer:

9 (1) may not count an outpatient visit for medication
10 management against the number of outpatient visits required to be
11 covered under Subsection (a)(1)(B); and

12 (2) must provide coverage for an outpatient visit
13 described by Subsection (a)(1)(B) under the same terms as the
14 coverage the issuer provides for an outpatient visit for the
15 treatment of physical illness. (V.T.I.C. Art. 3.51-14, Secs. 3(a),
16 (b).)

17 Source Law

18 Sec. 3. (a) Except as provided by Section 4 of
19 this article, a group health benefit plan:

20 (1) must provide coverage, based on
21 medical necessity, for the following treatment of
22 serious mental illness in each calendar year:

23 (A) 45 days of inpatient treatment;
24 and

25 (B) 60 visits for outpatient
26 treatment, including group and individual outpatient
27 treatment;

28 (2) may not include a lifetime limit on the
29 number of days of inpatient treatment or the number of
30 outpatient visits covered under the plan; and

31 (3) must include the same amount limits,
32 deductibles, copayments, and coinsurance factors for
33 serious mental illness as for physical illness.

34 (b) An issuer of a group health benefit plan may
35 not count toward the number of outpatient visits
36 required to be covered under Subsection (a)(1) of this
37 section an outpatient visit for the purpose of
38 medication management and must cover that outpatient
39 visit under the same terms and conditions as it covers
40 outpatient visits for treatment of physical illness.

41 Revised Law

42 Sec. 1355.005. MANAGED CARE PLAN AUTHORIZED. A group
43 health benefit plan issuer may provide or offer coverage required
44 by Section 1355.004 through a managed care plan. (V.T.I.C.
45 Art. 3.51-14, Sec. 3(c).)

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Source Law

(c) An issuer of a group health benefit plan may provide or offer coverage required under this section through a managed care plan.

Revised Law

Sec. 1355.006. COVERAGE FOR CERTAIN CONDITIONS RELATED TO CONTROLLED SUBSTANCE OR MARIHUANA NOT REQUIRED. (a) In this section, "controlled substance" and "marihuana" have the meanings assigned by Section 481.002, Health and Safety Code.

(b) This subchapter does not require a group health benefit plan to provide coverage for the treatment of:

(1) addiction to a controlled substance or marihuana that is used in violation of law; or

(2) mental illness that results from the use of a controlled substance or marihuana in violation of law. (V.T.I.C. Art. 3.51-14, Sec. 5.)

Source Law

Sec. 5. (a) This article may not be interpreted to require a group health benefit plan to provide coverage for treatment of:

(1) addiction to a controlled substance or marihuana that is used in violation of law; or

(2) mental illness resulting from the use of a controlled substance or marihuana in violation of law.

(b) In this section, "controlled substance" and "marihuana" have the meanings assigned by Section 481.002, Health and Safety Code.

Revised Law

Sec. 1355.007. SMALL EMPLOYER COVERAGE. An issuer of a group health benefit plan to a small employer must offer the coverage described by Section 1355.004 to the employer but is not required to provide the coverage if the employer rejects the coverage. (V.T.I.C. Art. 3.51-14, Sec. 4.)

Source Law

Sec. 4. An issuer of a group health benefit plan to a small employer must offer the coverage described in Section 3 of this article but is not required to provide the coverage if the small employer rejects the coverage.

[Sections 1355.008-1355.050 reserved for expansion]

1 SUBCHAPTER B. ALTERNATIVE MENTAL HEALTH TREATMENT BENEFITS

2 Revised Law

3 Sec. 1355.051. DEFINITIONS. In this subchapter:

4 (1) "Crisis stabilization unit" means a 24-hour
5 residential program that provides, usually for a short term,
6 intensive supervision and highly structured activities to
7 individuals who demonstrate a moderate to severe acute psychiatric
8 crisis.

9 (2) "Individual treatment plan" means a treatment plan
10 with specific attainable goals and objectives that are appropriate
11 to:

12 (A) the patient; and

13 (B) the program's treatment modality.

14 (3) "Residential treatment center for children and
15 adolescents" means a child-care institution that:

16 (A) is accredited as a residential treatment
17 center by:

18 (i) the Council on Accreditation;

19 (ii) the Joint Commission on Accreditation
20 of Healthcare Organizations; or

21 (iii) the American Association of
22 Psychiatric Services for Children; and

23 (B) provides residential care and treatment for
24 emotionally disturbed children and adolescents. (V.T.I.C.
25 Art. 3.72, Subsec. (a).)

26 Source Law

27 Art. 3.72. (a) In this article:

28 (1) "Crisis stabilization unit" means a
29 24-hour residential program that is usually short-term
30 in nature and that provides intensive supervision and
31 highly structured activities to persons who are
32 demonstrating an acute demonstrable psychiatric
33 crisis of moderate to severe proportions.

34 (2) "Residential treatment center for
35 children and adolescents" means a child-care
36 institution that provides residential care and
37 treatment for emotionally disturbed children and
38 adolescents and that is accredited as a residential
39 treatment center by the Council on Accreditation, the
40 Joint Commission on Accreditation of Hospitals, or the
41 American Association of Psychiatric Services for

1 Children.

2 (3) "Individual treatment plan" means a
3 treatment plan with specific attainable goals and
4 objectives appropriate to both the patient and the
5 treatment modality of the program.

6 Revisor's Note

7 Subsection (a)(2), V.T.I.C. Article 3.72, refers
8 to the "Joint Commission on Accreditation of
9 Hospitals." Throughout this chapter, the revised law
10 substitutes a reference to the "Joint Commission on
11 Accreditation of Healthcare Organizations" for the
12 quoted language because that is the proper name of the
13 organization to which that language refers.

14 Revised Law

15 Sec. 1355.052. APPLICABILITY OF SUBCHAPTER. This
16 subchapter applies to a group health benefit plan that is delivered
17 or issued for delivery in this state and that is:

18 (1) an accident and health insurance group policy;

19 (2) a group policy issued by a group hospital service
20 corporation operating under Chapter 842; or

21 (3) a group health care plan provided by a health
22 maintenance organization operating under Chapter 843. (V.T.I.C.
23 Art. 3.72, Subsec. (b) (part).)

24 Source Law

25 (b) . . . a group policy of accident and
26 sickness insurance delivered or issued for delivery to
27 a person in this state, including a group policy issued
28 by a group hospital service plan subject to Chapter 20
29 of this code and a group health care plan provided by a
30 health maintenance organization under the Texas Health
31 Maintenance Organization Act (Chapter 20A, Vernon's
32 Texas Insurance Code),

33 Revisor's Note

34 (1) Subsection (b), V.T.I.C. Article 3.72,
35 refers to a "group hospital service plan subject to
36 Chapter 20 of this code," meaning a corporation
37 operating under V.T.I.C. Chapter 20, revised as
38 Chapter 842 of this code. The term most frequently
39 used to refer to such a corporation is "group hospital
40 service corporation." Consequently, the revised law

1 substitutes "group hospital service corporation" for
2 "group hospital service plan" to provide consistent
3 use of terminology in this code.

4 (2) Subsection (b), V.T.I.C. Article 3.72,
5 describes a "group policy of accident and sickness
6 insurance." The revised law substitutes "group health
7 benefit plan" for "group policy of accident and
8 sickness insurance" because the term, as described,
9 includes coverage provided by a health maintenance
10 organization that is not insurance. Consequently,
11 "group health benefit plan" is a more accurate term.
12 The substitution of this term and related changes
13 necessary to ensure consistent terminology are made
14 throughout this subchapter.

15 Revised Law

16 Sec. 1355.053. REQUIRED COVERAGE FOR CERTAIN ILLNESSES AND
17 DISORDERS. A group health benefit plan that provides coverage for
18 treatment of mental or emotional illness or disorder for a covered
19 individual when the individual is confined in a hospital must also
20 provide coverage for treatment in a residential treatment center
21 for children and adolescents or a crisis stabilization unit that is
22 at least as favorable as the coverage the plan provides for
23 treatment of mental or emotional illness or disorder in a hospital.
24 (V.T.I.C. Art. 3.72, Subsec. (b) (part).)

25 Source Law

26 (b) Subject to the conditions of this article,
27 a . . . plan . . . that provides coverage for
28 treatment of mental or emotional illness or disorder
29 for an insured when confined in a hospital must also
30 include coverage that is not less favorable for
31 treatment in a residential treatment center for
32 children and adolescents or from a crisis
33 stabilization unit.

34 Revised Law

35 Sec. 1355.054. CONDITIONS FOR COVERAGE. (a) Benefits of
36 coverage provided under this subchapter may be used only in a
37 situation in which:

1 (1) the covered individual has a serious mental
2 illness that requires confinement of the individual in a hospital
3 unless treatment is available through a residential treatment
4 center for children and adolescents or a crisis stabilization unit;
5 and

6 (2) the covered individual's mental illness:

7 (A) substantially impairs the individual's
8 thought, perception of reality, emotional process, or judgment; or

9 (B) as manifested by the individual's recent
10 disturbed behavior, grossly impairs the individual's behavior.

11 (b) The service for which benefits are to be paid from
12 coverage provided under this subchapter must be:

13 (1) based on an individual treatment plan for the
14 covered individual; and

15 (2) provided by a service provider licensed or
16 operated by the appropriate state agency to provide those services.

17 (c) Benefits under coverage provided under this subchapter
18 are subject to the same benefit maximums, durational limitations,
19 deductibles, and coinsurance factors that apply to inpatient
20 psychiatric treatment under the coverage. (V.T.I.C. Art. 3.72,
21 Subsec. (c).)

22 Source Law

23 (c) Coverage provided under this article is
24 subject to the following conditions:

25 (1) the benefits provided by this article
26 may be used only in situations in which the insured has
27 a serious mental illness which substantially impairs
28 the person's thought, perception of reality, emotional
29 process, or judgment or grossly impairs behavior as
30 manifested by recent disturbed behavior and which
31 would otherwise necessitate confinement in a hospital
32 if such care and treatment were not available through a
33 crisis stabilization unit or residential treatment
34 center for children and adolescents;

35 (2) the services rendered for which
36 benefits are to be paid must be based on an individual
37 treatment plan;

38 (3) providers of services for which
39 benefits are to be paid must be licensed or operated by
40 the appropriate state agency or board to provide those
41 services; and

42 (4) the benefits are subject to the same
43 benefit maximums, durational limits, deductibles, and
44 coinsurance factors that apply to inpatient
45 psychiatric treatment.

1 Revisor's Note

2 Subsection (c)(3), V.T.I.C. Article 3.72, refers
3 to the "appropriate state agency or board." The
4 revised law omits the reference to a state board as
5 unnecessary because a state board is included in the
6 meaning of "state agency."

7 Revised Law

8 Sec. 1355.055. DETERMINATIONS FOR TREATMENT IN A
9 RESIDENTIAL TREATMENT CENTER FOR CHILDREN AND
10 ADOLESCENTS. (a) Treatment in a residential treatment center for
11 children and adolescents must be determined as if necessary care
12 and treatment were inpatient care and treatment in a hospital.

13 (b) For the purposes of determining policy benefits and
14 benefit maximums, each two days of treatment in a residential
15 treatment center for children and adolescents is the equivalent of
16 one day of treatment of mental or emotional illness or disorder in a
17 hospital or inpatient program. (V.T.I.C. Art. 3.72, Subsec. (d).)

18 Source Law

19 (d) Treatment in a residential treatment center
20 for children and adolescents shall be determined as if
21 necessary care and treatment in a residential
22 treatment center for children and adolescents were
23 inpatient care and treatment in a hospital, and each
24 two days of treatment in a residential treatment
25 center for children and adolescents will be considered
26 equal to one day of treatment of mental or emotional
27 illness or disorder in a hospital or inpatient program
28 for the purpose of determining policy benefits and
29 benefit maximums.

30 Revised Law

31 Sec. 1355.056. DETERMINATIONS FOR TREATMENT BY A CRISIS
32 STABILIZATION UNIT. (a) Treatment by a crisis stabilization unit
33 must be determined as if necessary care and treatment were
34 inpatient care and treatment in a hospital.

35 (b) For the purposes of determining plan benefits and
36 benefit maximums, each two days of treatment in a crisis
37 stabilization unit is the equivalent of one day of treatment of
38 mental or emotional illness or disorder in a hospital or inpatient
39 program.

1 (c) Treatment provided to an individual by a crisis
2 stabilization unit licensed or certified by the Texas Department of
3 Mental Health and Mental Retardation shall be reimbursed. (V.T.I.C.
4 Art. 3.72, Subsec. (e).)

5 Source Law

6 (e) Treatment provided through crisis
7 stabilization units shall be determined as if
8 necessary care and treatment through crisis
9 stabilization units were inpatient care and treatment
10 in a hospital, and two days in a crisis stabilization
11 unit are considered equal to one day of treatment of
12 mental or emotional illness or disorder in a hospital
13 or inpatient program for the purpose of determining
14 policy benefits and benefit maximums. Treatment
15 provided through crisis stabilization units shall be
16 reimbursed for facilities licensed or certified by the
17 Texas Department of Mental Health and Mental
18 Retardation.

19 Revised Law

20 Sec. 1355.057. REVIEW AND ADJUSTMENT OF MINIMUM RATIOS OF
21 REIMBURSEMENT. (a) The commissioner shall monitor and review the
22 minimum ratios of reimbursement for alternative treatments
23 required by Sections 1355.055 and 1355.056.

24 (b) If the commissioner finds that the limits provided by
25 this subchapter are creating an artificial increase in the costs of
26 services, the commissioner by rule may adjust the ratios to the
27 extent necessary to prevent the artificial increase.

28 (c) Before the commissioner adjusts a ratio under
29 Subsection (b), the commissioner must give notice and hold a
30 hearing to:

31 (1) consider information related to the adjustment;

32 and

33 (2) determine whether the information justifies the
34 adjustment.

35 (d) The department shall review the reimbursement ratios at
36 least every two years. (V.T.I.C. Art. 3.72, Subsec. (f) (part).)

37 Source Law

38 (f) The State Board of Insurance shall monitor
39 and review the minimum ratios of reimbursement
40 required by Sections (d) and (e) of this article for
41 alternative treatments, and if the board determines
42 that the limits provided by this article are creating

1 an artificial rise in costs of services, the board by
2 rule may adjust the ratios to the extent necessary to
3 prevent this artificial rise in costs of services.
4 Before the board adopts a rule adjusting a ratio of
5 reimbursement, the board shall give notice and hold a
6 hearing to consider the data relating to the
7 adjustment and to determine if that data justifies the
8 adjustment. . . . the board shall make subsequent
9 reviews of the ratios of reimbursement at least every
10 two years

11 Revisor's Note

12 (1) Subsection (f), V.T.I.C. Article 3.72,
13 refers to "[t]he State Board of Insurance." Chapter
14 685, Acts of the 73rd Legislature, Regular Session,
15 1993, abolished the board and transferred its
16 functions to the commissioner of insurance and the
17 Texas Department of Insurance. Throughout this
18 subchapter, references to the board have been changed
19 appropriately.

20 (2) Subsection (f), V.T.I.C. Article 3.72,
21 provides that the State Board of Insurance (now Texas
22 Department of Insurance) must make the first review of
23 reimbursement ratios before January 1, 1990. The
24 revised law omits the references to the initial review
25 because that provision is executed. The omitted law
26 reads:

27 (f) . . . The first review by the
28 board of ratios of reimbursement under this
29 section must be made before January 1, 1990,
30 and . . . [every two years] after the first
31 review.

32 Revised Law

33 Sec. 1355.058. ASSISTANCE OF THE TEXAS DEPARTMENT OF MENTAL
34 HEALTH AND MENTAL RETARDATION. (a) The Texas Department of
35 Mental Health and Mental Retardation shall assist the department in
36 carrying out the department's responsibilities under this
37 subchapter.

38 (b) The department and the Texas Department of Mental Health
39 and Mental Retardation by rule may adopt a memorandum of
40 understanding to carry out this subchapter. (V.T.I.C. Art. 3.72,
41 Subsec. (g).)

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Source Law

(g) The Texas Department of Mental Health and Mental Retardation shall assist the board in carrying out its responsibilities under this article. To carry out this article, the State Board of Insurance and the Texas Department of Mental Health and Mental Retardation may by rule adopt memoranda of understanding.

[Sections 1355.059-1355.100 reserved for expansion]

SUBCHAPTER C. PSYCHIATRIC DAY TREATMENT FACILITIES

Revised Law

Sec. 1355.101. DEFINITION. In this subchapter, "psychiatric day treatment facility" means a mental health facility that:

(1) provides treatment for individuals suffering from acute mental and nervous disorders in a structured psychiatric program using individualized treatment plans with specific attainable goals and objectives that are appropriate to the patient and the program's treatment modality; and

(2) is clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology. (V.T.I.C. Art. 3.70-2, Sec. (F) (part).)

Source Law

(F) . . . For the purpose of this subsection a psychiatric day treatment facility is a mental health facility which provides treatment for individuals suffering from acute, mental and nervous disorders in a structured psychiatric program utilizing individualized treatment plans with specific attainable goals and objectives appropriate both to the patient and the treatment modality of the program and that is clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

Revised Law

Sec. 1355.102. APPLICABILITY OF SUBCHAPTER. This subchapter applies to a group policy of accident and health insurance delivered or issued for delivery in this state, including a group policy issued by a group hospital service corporation operating under Chapter 842. (V.T.I.C. Art. 3.70-2, Sec. (F) (part).)

1 to Section (F), V.T.I.C. Article 3.70-2, are revised
2 as Chapter 1201 of this code. Section 1355.103 is
3 added to indicate the applicability of those general
4 provisions to this subchapter. For the convenience of
5 the reader, the revised law includes general
6 descriptions of some of the provisions of Chapter
7 1201.

8 Revised Law

9 Sec. 1355.104. REQUIRED COVERAGE FOR TREATMENT IN
10 PSYCHIATRIC DAY TREATMENT FACILITY. (a) A group insurance policy
11 that provides coverage for treatment of mental or emotional illness
12 or disorder when an individual is confined in a hospital must also
13 provide coverage for treatment obtained under the direction and
14 continued medical supervision of a doctor of medicine or doctor of
15 osteopathy in a psychiatric day treatment facility that provides
16 organizational structure and individualized treatment plans
17 separate from an inpatient program.

18 (b) The psychiatric day treatment facility coverage
19 required by this section may not be less favorable than the hospital
20 coverage and must be subject to the same durational limits,
21 deductibles, and coinsurance factors.

22 (c) A group insurance policy subject to this section may
23 require that:

24 (1) the treatment obtained in a psychiatric day
25 treatment facility be provided by a facility that treats a patient
26 for not more than 8 hours in any 24-hour period;

27 (2) the attending physician certify that the treatment
28 is in lieu of hospitalization; and

29 (3) the psychiatric day treatment facility be
30 accredited by the Program for Psychiatric Facilities, or its
31 successor, of the Joint Commission on Accreditation of Healthcare
32 Organizations. (V.T.I.C. Art. 3.70-2, Sec. (F) (part).)

33 Source Law

34 (F) A group policy . . . that provides coverage

1 for treatment of mental or emotional illness or
2 disorder for a person when confined in a hospital must
3 also provide that coverage, which is not less
4 favorable, shall be applicable for treatment under the
5 direction and continued medical supervision of a
6 doctor of medicine or doctor of osteopathy in a
7 psychiatric day treatment facility that provides
8 organizational structure and individualized treatment
9 plans separate from an in-patient program; subject to
10 the same durational limits, deductibles, and
11 coinsurance factors. . . . Any such policy may require
12 that the treatment must be provided by a day treatment
13 facility that treats a patient for not more than eight
14 hours in any 24-hour period, that the attending
15 physician certifies that such treatment is in lieu of
16 hospitalization, and that the psychiatric treatment
17 facility is accredited by the Program for Psychiatric
18 Facilities, or its successor, of the Joint Commission
19 on Accreditation of Hospitals. . . .

20 Revised Law

21 Sec. 1355.105. DETERMINATIONS FOR TREATMENT IN PSYCHIATRIC
22 DAY TREATMENT FACILITY. (a) Benefits provided under this
23 subchapter shall be determined as if necessary care and treatment
24 in a psychiatric day treatment facility were inpatient care and
25 treatment in a hospital.

26 (b) For the purpose of determining policy benefits and
27 benefit maximums, each full day of treatment in a psychiatric day
28 treatment facility is the equivalent of one-half of one day of
29 treatment of mental or emotional illness or disorder in a hospital
30 or inpatient program. (V.T.I.C. Art. 3.70-2, Sec. (F) (part).)

31 Source Law

32 (F) . . . Any benefits so provided shall be
33 determined as if necessary care and treatment in a
34 psychiatric day treatment facility were in-patient
35 care and treatment in a hospital, and each full day of
36 treatment in a psychiatric day treatment facility
37 shall be considered equal to one-half of one day of
38 treatment of mental or emotional illness or disorder
39 in a hospital or in-patient program for the purpose of
40 determining policy benefits and benefit
41 maximums. . . .

42 Revised Law

43 Sec. 1355.106. OFFER OF COVERAGE REQUIRED; ALTERNATIVE
44 BENEFITS. (a) An insurer shall offer, and a policyholder is
45 entitled to reject, coverage under a group insurance policy for
46 treatment of mental or emotional illness or disorder when confined
47 in a hospital or in a psychiatric day treatment facility.

48 (b) A policyholder may select an alternative level of

1 benefits under the group insurance policy if the alternative level
2 is offered by or negotiated with the insurer.

3 (c) The alternative level of benefits must provide policy
4 benefits and benefit maximums for treatment in a psychiatric day
5 treatment facility equal to at least one-half of that provided for
6 treatment in a hospital, except that benefits for treatment in a
7 psychiatric day treatment facility may not exceed the usual and
8 customary charges of the facility. (V.T.I.C. Art. 3.70-2, Sec. (F)
9 (part).)

10 Source Law

11 (F) . . . An insurer shall offer and the
12 policyholder shall have the right to reject such
13 coverage for treatment of mental or emotional illness
14 or disorder when confined in a hospital or in a
15 psychiatric day treatment facility or may select an
16 alternative level of benefits thereunder if such
17 coverage is offered by or negotiated with such
18 insurer, service plan corporation or . . . provided,
19 however, any such alternative level of benefits shall
20 provide policy benefits and benefit maximums for
21 treatment in psychiatric day treatment facilities
22 equal to at least one half of that provided for
23 treatment in hospital facilities, but not to exceed
24 the usual and customary charge of the psychiatric day
25 treatment facility. . . .

26 Revisor's Note

27 Section (F), V.T.I.C. Article 3.70-2, refers to
28 an "insurer" and to an "insurer [or] service plan
29 corporation," meaning a group hospital service
30 corporation operating under V.T.I.C. Chapter 20,
31 revised as Chapter 842 of this code. The portion of
32 Section (F) that is revised as Section 1355.102
33 provides that Section (F), revised as this subchapter,
34 applies to a group hospital service corporation. For
35 consistency of terminology, the revised law uses the
36 term "insurer" throughout this subchapter.

37 [Sections 1355.107-1355.150 reserved for expansion]

38 SUBCHAPTER D. CERTAIN COVERAGES PROVIDED BY LOCAL GOVERNMENTS

39 Revised Law

40 Sec. 1355.151. PROHIBITION ON EXCLUSION OR LIMITATION OF
41 CERTAIN COVERAGES. (a) In this section, "serious mental illness"

1 has the meaning assigned by Section 1355.001.

2 (b) A political subdivision that provides group health
3 insurance coverage, health maintenance organization coverage, or
4 self-insured health care coverage to the political subdivision's
5 officers or employees may not contract for or provide coverage that
6 is less extensive for serious mental illness than the coverage
7 provided for any other physical illness. (V.T.I.C. Art. 3.51-5A,
8 Subsecs. (a) (part), (b).)

9 Source Law

10 Art. 3.51-5A. (a) A municipality, county,
11 school district, district created under Article III,
12 Section 52, or Article XVI, Section 59, of the Texas
13 Constitution, or other political subdivision of the
14 state that provides group health insurance coverage,
15 health maintenance organization coverage, or
16 self-insured health care coverage to its officers or
17 employees or to both its officers and employees may not
18 contract for or provide coverage that:

19
20 (2) is less extensive for serious mental
21 illness than the coverage provided for any other
22 physical illness.

23 (b) For purposes of this article, "serious
24 mental illness" has the meaning assigned by Section 1,
25 Article 3.51-14, of this code.

26 Revisor's Note

27 Subsection (a), V.T.I.C. Article 3.51-5A, refers
28 to "[a] municipality, county, school district,
29 district created under Article III, Section 52, or
30 Article XVI, Section 59, of the Texas Constitution, or
31 other political subdivision of the state." The
32 revised law substitutes the term "political
33 subdivision" for the quoted language because each type
34 of entity specified is included in the meaning of
35 "political subdivision."

36 [Sections 1355.152-1355.200 reserved for expansion]

37 SUBCHAPTER E. BENEFITS FOR TREATMENT BY

38 TAX-SUPPORTED INSTITUTION

39 Revised Law

40 Sec. 1355.201. APPLICABILITY OF GENERAL PROVISIONS OF OTHER
41 LAW. The provisions of Chapter 1201, including provisions

1 relating to the applicability, purpose, and enforcement of that
2 chapter, construction of policies under that chapter, rulemaking
3 under that chapter, and definitions of terms applicable in that
4 chapter, apply to this subchapter. (New.)

5 Revisor's Note

6 Section (D), V.T.I.C. Article 3.70-2, was enacted
7 as an amendment to Chapter 397, Acts of the 54th
8 Legislature, Regular Session, 1955, published as
9 Articles 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B,
10 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9,
11 3.70-10, and 3.70-11, Vernon's Texas Insurance Code.
12 The majority of these articles, which include general
13 provisions applicable to Section (D), V.T.I.C. Article
14 3.70-2, are revised as Chapter 1201 of this code.
15 Section 1355.201 is added to indicate the
16 applicability of those general provisions to this
17 subchapter. For the convenience of the reader, the
18 revised law includes general descriptions of some of
19 the provisions of Chapter 1201.

20 Revised Law

21 Sec. 1355.202. PROHIBITION OF EXCLUSION OF MENTAL HEALTH OR
22 MENTAL RETARDATION BENEFITS FOR TREATMENT BY TAX-SUPPORTED
23 INSTITUTION. (a) An individual or group accident and health
24 insurance policy delivered or issued for delivery to a person in
25 this state that provides coverage for mental illness or mental
26 retardation may not exclude benefits under that coverage for
27 support, maintenance, and treatment provided by a tax-supported
28 institution of this state, or by a community center for mental
29 health or mental retardation services, that regularly and
30 customarily charges patients who are not indigent for those
31 services.

32 (b) In determining whether a patient is not indigent, as
33 provided by Subchapter B, Chapter 552, Health and Safety Code, a
34 tax-supported institution of this state or a community center for

1 mental health or mental retardation services shall consider any
2 insurance policy or policies that provide coverage to the patient
3 for mental illness or mental retardation. (V.T.I.C. Art. 3.70-2,
4 Sec. (D).)

5 Source Law

6 (D) No individual policy or group policy of
7 accident and sickness insurance delivered or issued
8 for delivery to any person in this state which provides
9 coverage for mental illness or mental retardation or
10 both mental illness and mental retardation shall
11 exclude benefits for the support, maintenance and
12 treatment of such mental illness or mental retardation
13 provided by a tax supported institution of the State of
14 Texas, including community centers for mental health
15 and mental retardation services, provided charges for
16 the care or treatment of such mental illness or mental
17 retardation are regularly and customarily charged to
18 non-indigent patients by such tax supported
19 institution. In determining whether or not a patient
20 is a non-indigent patient, as provided in Chapter 152,
21 Acts of the 45th Legislature, Regular Session, 1937
22 (Article 3196a, Vernon's Texas Civil Statutes), such
23 tax supported institution shall consider any insurance
24 policy (or policies) which provides coverage for
25 mental illness or mental retardation or both mental
26 illness and mental retardation to such patients.

27 Revisor's Note

28 Section (D), V.T.I.C. Article 3.70-2, refers to
29 "Chapter 152, Acts of the 45th Legislature, Regular
30 Session, 1937 (Article 3196a, Vernon's Texas Civil
31 Statutes)." That statute was codified in 1991 as
32 Subchapter B, Chapter 552, Health and Safety Code, and
33 the revised law is drafted accordingly.

34 CHAPTER 1356. LOW-DOSE MAMMOGRAPHY

35 Sec. 1356.001. DEFINITION 924
36 Sec. 1356.002. APPLICABILITY OF CHAPTER 925
37 Sec. 1356.003. APPLICABILITY OF GENERAL PROVISIONS
38 OF OTHER LAW 926
39 Sec. 1356.004. EXCEPTION. 926
40 Sec. 1356.005. COVERAGE REQUIRED 927

41 CHAPTER 1356. LOW-DOSE MAMMOGRAPHY

42 Revised Law

43 Sec. 1356.001. DEFINITION. In this chapter, "low-dose
44 mammography" means the x-ray examination of the breast using

1 equipment dedicated specifically for mammography, including an
2 x-ray tube, filter, compression device, screens, films, and
3 cassettes, with an average radiation exposure delivery of less than
4 one rad mid-breast, with two views for each breast. (V.T.I.C.
5 Art. 3.70-2, Sec. (H) (part), as amended Acts 70th Leg., R.S., Ch.
6 1091.)

7 Source Law

8 (H) In this section, "low-dose mammography"
9 means the X-ray examination of the breast using
10 equipment dedicated specifically for mammography,
11 including the X-ray tube, filter, compression device,
12 screens, films, and cassettes, with an average
13 radiation exposure delivery of less than one rad
14 mid-breast, with two views for each breast. . . .

15 Revised Law

16 Sec. 1356.002. APPLICABILITY OF CHAPTER. This chapter
17 applies only to a health benefit plan that is delivered, issued for
18 delivery, or renewed in this state and that is an individual or
19 group accident and health insurance policy, including a policy
20 issued by a group hospital service corporation operating under
21 Chapter 842. (V.T.I.C. Art. 3.70-2, Sec. (H) (part), as amended
22 Acts 70th Leg., R.S., Ch. 1091.)

23 Source Law

24 (H) . . . Each individual policy or group
25 policy of accident and sickness insurance . . . that
26 is delivered, issued for delivery, or renewed in this
27 state, . . . including policies issued by companies
28 subject to Chapter 20, Insurance Code,

29 Revisor's Note

30 (1) Section (H), V.T.I.C. Article 3.70-2, as
31 amended by Chapter 1091, Acts of the 70th Legislature,
32 Regular Session, 1987, refers to policies of "accident
33 and sickness" insurance. For consistency with modern
34 usage, the revised law substitutes "accident and
35 health" for "accident and sickness."

36 (2) Section (H), V.T.I.C. Article 3.70-2, as
37 amended by Chapter 1091, Acts of the 70th Legislature,
38 Regular Session, 1987, refers to policies issued by
39 "companies" subject to V.T.I.C. Chapter 20, revised as

1 Chapter 842. The term most frequently used to describe
2 such a company is "group hospital service
3 corporation." Therefore, the revised law substitutes
4 "group hospital service corporation" for "companies."

5 Revised Law

6 Sec. 1356.003. APPLICABILITY OF GENERAL PROVISIONS OF OTHER
7 LAW. The provisions of Chapter 1201, including provisions
8 relating to the applicability, purpose, and enforcement of that
9 chapter, construction of policies under that chapter, rulemaking
10 under that chapter, and definitions of terms applicable in that
11 chapter, apply to this chapter. (New.)

12 Revisor's Note

13 Chapter 397, Acts of the 54th Legislature,
14 Regular Session, 1955, published as V.T.I.C. Articles
15 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4,
16 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and
17 3.70-11, contains general provisions applicable to
18 Section (H), V.T.I.C. Article 3.70-2, as amended by
19 Chapter 1091, Acts of the 70th Legislature, Regular
20 Session, 1987, revised as this chapter. The majority
21 of these articles are revised in this code as Chapter
22 1201. Section 1356.003 is added to indicate the
23 applicability of those general provisions to this
24 chapter. For the convenience of the reader, the
25 revised law includes general descriptions of some of
26 the applicable provisions of Chapter 1201.

27 Revised Law

28 Sec. 1356.004. EXCEPTION. This chapter does not apply to a
29 plan that provides coverage only for a specified disease or for
30 another limited benefit. (V.T.I.C. Art. 3.70-2, Sec. (H) (part), as
31 amended Acts 70th Leg., R.S., Ch. 1091.)

32 Source Law

33 (H) . . . [Each individual policy or group
34 policy of accident and sickness insurance . . . that
35 is delivered, issued for delivery, or renewed in this

1 state,] except for policies that provide coverage for
2 specified disease or other limited benefit coverage
3 but

4 Revised Law

5 Sec. 1356.005. COVERAGE REQUIRED. (a) A health benefit
6 plan that provides coverage to a female who is 35 years of age or
7 older must include coverage for an annual screening by low-dose
8 mammography for the presence of occult breast cancer.

9 (b) Coverage required by this section:

10 (1) may not be less favorable than coverage for other
11 radiological examinations under the plan; and

12 (2) must be subject to the same dollar limits,
13 deductibles, and coinsurance factors as coverage for other
14 radiological examinations under the plan. (V.T.I.C. Art. 3.70-2,
15 Sec. (H) (part), as amended Acts 70th Leg., R.S., Ch. 1091.)

16 Source Law

17 (H) . . . [Each individual policy or group
18 policy of accident and sickness insurance] that covers
19 a female 35 years old or older and [that is delivered,
20 issued for delivery, or renewed in this state, except
21 for policies that provide coverage for specified
22 disease or other limited benefit coverage but
23 including policies issued by companies subject to
24 Chapter 20, Insurance Code,] must include coverage for
25 an annual screening by low-dose mammography for the
26 presence of occult breast cancer within the provisions
27 of the policy that is not less favorable than for other
28 radiological examinations and subject to the same
29 dollar limits, deductibles, and co-insurance factors.

30 CHAPTER 1357. MASTECTOMY

31 SUBCHAPTER A. RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY

32 Sec. 1357.001. DEFINITIONS 928
33 Sec. 1357.002. APPLICABILITY OF SUBCHAPTER 929
34 Sec. 1357.003. EXCEPTION. 930
35 Sec. 1357.004. COVERAGE REQUIRED 932
36 Sec. 1357.005. PROHIBITED CONDUCT 933
37 Sec. 1357.006. NOTICE OF COVERAGE. 933
38 Sec. 1357.007. RULES 934

39 [Sections 1357.008-1357.050 reserved for expansion]

1 SUBCHAPTER B. HOSPITAL STAY FOLLOWING MASTECTOMY

2 AND CERTAIN RELATED PROCEDURES

3 Sec. 1357.051. DEFINITION 935

4 Sec. 1357.052. APPLICABILITY OF SUBCHAPTER 935

5 Sec. 1357.053. EXCEPTION. 937

6 Sec. 1357.054. COVERAGE REQUIRED 938

7 Sec. 1357.055. PROHIBITED CONDUCT 939

8 Sec. 1357.056. NOTICE OF COVERAGE. 940

9 Sec. 1357.057. RULES 940

10 CHAPTER 1357. MASTECTOMY

11 SUBCHAPTER A. RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY

12 Revised Law

13 Sec. 1357.001. DEFINITIONS. In this subchapter:

14 (1) "Breast reconstruction" means reconstruction of a

15 breast incident to mastectomy to restore or achieve breast

16 symmetry. The term includes surgical reconstruction of a breast on

17 which mastectomy has been performed and surgical reconstruction of

18 a breast on which mastectomy has not been performed.

19 (2) "Enrollee" means an individual entitled to

20 coverage under a health benefit plan. (V.T.I.C. Art. 21.53I, Secs.

21 1(2), (3).)

22 Source Law

23 Art. 21.53I

24 Sec. 1. In this article:

25 (2) "Breast reconstruction" means

26 reconstruction of a breast incident to mastectomy to

27 restore or achieve breast symmetry. The term includes

28 surgical reconstruction of a breast on which

29 mastectomy surgery has been performed and surgical

30 reconstruction of a breast on which mastectomy surgery

31 has not been performed.

32 (3) "Enrollee" means a person entitled to

33 coverage under a health benefit plan.

34 Revisor's Note

35 (1) Section 1(1), V.T.I.C. Article 21.53I,

36 defines "health benefit plan." The revised law omits

37 the definition as unnecessary because Section 2 of

38 that article, revised as Sections 1357.002 and

1 1357.003, specifies the types of health benefit plans
2 to which this subchapter applies, and thus the defined
3 term is not helpful to the reader. The omitted law
4 reads:

5 (1) "Health benefit plan" means
6 a plan described by Section 2 of this
7 article.

8 (2) Section 1(2), V.T.I.C. Article 21.53I,
9 refers to a "mastectomy surgery." The revised law
10 substitutes "mastectomy" for "mastectomy surgery"
11 because the terms are synonymous, and "mastectomy" is
12 the term used throughout this chapter.

13 Revised Law

14 Sec. 1357.002. APPLICABILITY OF SUBCHAPTER. This
15 subchapter applies only to a health benefit plan that provides
16 benefits for medical or surgical expenses incurred as a result of a
17 health condition, accident, or sickness, including an individual,
18 group, blanket, or franchise insurance policy or insurance
19 agreement, a group hospital service contract, or an individual or
20 group evidence of coverage or similar coverage document that is
21 offered by:

22 (1) an insurance company;

23 (2) a group hospital service corporation operating
24 under Chapter 842;

25 (3) a fraternal benefit society operating under
26 Chapter 885;

27 (4) a stipulated premium company operating under
28 Chapter 884;

29 (5) a reciprocal exchange operating under Chapter 942;

30 (6) a health maintenance organization operating under
31 Chapter 843;

32 (7) a multiple employer welfare arrangement that holds
33 a certificate of authority under Chapter 846; or

34 (8) an approved nonprofit health corporation that
35 holds a certificate of authority under Chapter 844. (V.T.I.C.

1 Art. 21.53I, Sec. 2(a).)

2 Source Law

3 Sec. 2. (a) This article applies only to a
4 health benefit plan that provides benefits for medical
5 or surgical expenses incurred as a result of a health
6 condition, accident, or sickness, including an
7 individual, group, blanket, or franchise insurance
8 policy or insurance agreement, a group hospital
9 service contract, or an individual or group evidence
10 of coverage or similar coverage document that is
11 offered by:

- 12 (1) an insurance company;
- 13 (2) a group hospital service corporation
14 operating under Chapter 20 of this code;
- 15 (3) a fraternal benefit society operating
16 under Chapter 10 of this code;
- 17 (4) a stipulated premium insurance company
18 operating under Chapter 22 of this code;
- 19 (5) a reciprocal exchange operating under
20 Chapter 19 of this code;
- 21 (6) a health maintenance organization
22 operating under the Texas Health Maintenance
23 Organization Act (Chapter 20A, Vernon's Texas
24 Insurance Code);
- 25 (7) a multiple employer welfare
26 arrangement that holds a certificate of authority
27 under Article 3.95-2 of this code; or
- 28 (8) an approved nonprofit health
29 corporation that holds a certificate of authority
30 issued by the commissioner under Article 21.52F of
31 this code.

32 Revisor's Note

33 Section 2(a)(8), V.T.I.C. Article 21.53I, refers
34 to an approved nonprofit health corporation that holds
35 a certificate of authority "issued by the
36 commissioner" under Article 21.52F of this code. The
37 revised law omits the quoted language as unnecessary
38 because Article 21.52F, revised as Chapter 844 of this
39 code, requires the commissioner to issue the
40 certificate of authority.

41 Revised Law

42 Sec. 1357.003. EXCEPTION. This subchapter does not apply
43 to:

- 44 (1) a plan that provides coverage:
 - 45 (A) only for a specified disease or another
46 limited benefit, other than benefits for cancer;
 - 47 (B) only for accidental death or dismemberment;
 - 48 (C) only for wages or payments in lieu of wages

1 for a period during which an employee is absent from work because of
2 sickness or injury;

3 (D) only for credit insurance;

4 (E) only for dental or vision care;

5 (F) only for indemnity for hospital confinement;

6 or

7 (G) as a supplement to a liability insurance
8 policy;

9 (2) a Medicare supplemental policy as defined by
10 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),
11 as amended;

12 (3) a workers' compensation insurance policy;

13 (4) medical payment insurance coverage provided under
14 a motor vehicle insurance policy; or

15 (5) a long-term care insurance policy, including a
16 nursing home fixed indemnity policy, unless the commissioner
17 determines that the policy provides benefit coverage so
18 comprehensive that the policy is a health benefit plan as described
19 by Section 1357.002. (V.T.I.C. Art. 21.53I, Sec. 2(b).)

20 Source Law

21 (b) This article does not apply to:

22 (1) a plan that provides coverage:

23 (A) only for a specified disease or
24 other limited benefit except for cancer;

25 (B) only for accidental death or
26 dismemberment;

27 (C) only for wages or payments in
28 lieu of wages for a period during which an employee is
29 absent from work because of sickness or injury;

30 (D) only for credit insurance;

31 (E) only for dental or vision care;

32 (F) only for indemnity for hospital
33 confinement; or

34 (G) as a supplement to liability
35 insurance;

36 (2) a Medicare supplemental policy as
37 defined by Section 1882(g)(1), Social Security Act (42
38 U.S.C. Section 1395ss), as amended;

39 (3) workers' compensation insurance
40 coverage;

41 (4) medical payment insurance issued as
42 part of a motor vehicle insurance policy; or

43 (5) a long-term care policy, including a
44 nursing home fixed indemnity policy, unless the
45 commissioner determines that the policy provides
46 benefit coverage so comprehensive that the policy is a
47 health benefit plan as described by Subsection (a) of

1 this section.

2 Revised Law

3 Sec. 1357.004. COVERAGE REQUIRED. (a) A health benefit
4 plan that provides coverage for mastectomy must provide coverage
5 for:

6 (1) reconstruction of the breast on which the
7 mastectomy has been performed;

8 (2) surgery and reconstruction of the other breast to
9 achieve a symmetrical appearance; and

10 (3) prostheses and treatment of physical
11 complications, including lymphedemas, at all stages of mastectomy.

12 (b) Coverage required under this section:

13 (1) shall be provided in a manner determined to be
14 appropriate in consultation with the attending physician and the
15 enrollee;

16 (2) may be subject to annual deductibles, copayments,
17 and coinsurance that are consistent with annual deductibles,
18 copayments, and coinsurance required for other coverage under the
19 health benefit plan; and

20 (3) may not be subject to dollar limits other than the
21 lifetime maximum benefits under the plan. (V.T.I.C. Art. 21.53I,
22 Sec. 3.)

23 Source Law

24 Sec. 3. (a) A health benefit plan that
25 provides coverage for mastectomy must provide coverage
26 for:

27 (1) reconstruction of the breast on which
28 the mastectomy has been performed;

29 (2) surgery and reconstruction of the
30 other breast to achieve a symmetrical appearance; and

31 (3) prostheses and treatment of physical
32 complications, including lymphedemas, at all stages of
33 mastectomy.

34 (b) The coverage described by this section shall
35 be provided in a manner determined to be appropriate in
36 consultation with the attending physician and the
37 enrollee.

38 (c) The coverage described by this section may
39 be subject to annual deductibles, copayments, and
40 coinsurance that are consistent with annual
41 deductibles, copayments, and coinsurance required for
42 other benefits under the health benefit plan.

43 (d) The benefits required by this subchapter may
44 not be subject to dollar limitations other than the
45 health benefit plan's lifetime maximum benefits.

1 Revised Law

2 Sec. 1357.005. PROHIBITED CONDUCT. (a) An issuer of a
3 health benefit plan may not:

4 (1) offer a financial incentive for an enrollee to not
5 receive breast reconstruction or to waive the coverage required
6 under this subchapter;

7 (2) condition, limit, or deny the eligibility of a
8 person to enroll in the plan or to renew coverage under the terms of
9 the plan solely to avoid the requirements of this subchapter; or

10 (3) reduce or limit the reimbursement or amount paid
11 to, or otherwise penalize, an attending physician or provider or
12 provide a financial incentive or other benefit to an attending
13 physician or provider to induce the physician or provider to
14 provide care to an enrollee in a manner that is inconsistent with
15 this subchapter.

16 (b) This section does not prevent an issuer of a health
17 benefit plan from negotiating with a physician or provider the
18 level and type of reimbursement that the physician or provider will
19 receive for care provided in accordance with this subchapter.

20 (V.T.I.C. Art. 21.53I, Sec. 4.)

21 Source Law

22 Sec. 4. (a) A health benefit plan may not:

23 (1) offer a financial incentive for a
24 patient to forgo breast reconstruction or to waive the
25 coverage required by Section 3 of this article;

26 (2) condition, limit, or deny the
27 eligibility of an enrollee to enroll in the health
28 benefit plan or to renew coverage under the terms of
29 the plan solely for the purpose of avoiding the
30 requirements of this article; or

31 (3) reduce or limit the reimbursement or
32 payment of, or otherwise penalize, an attending
33 physician or provider or provide financial incentives
34 or other benefits to an attending physician or
35 provider to induce the physician or provider to
36 provide care to an enrollee in a manner inconsistent
37 with this article.

38 (b) This section may not be construed to prevent
39 a health benefit plan from negotiating with a
40 physician or provider the level and type of
41 reimbursement that physician or provider will receive
42 for care provided in accordance with this article.

43 Revised Law

44 Sec. 1357.006. NOTICE OF COVERAGE. (a) An issuer of a

1 health benefit plan that provides coverage under this subchapter
2 shall provide to each enrollee notice of the availability of the
3 coverage.

4 (b) The notice must be provided in accordance with rules
5 adopted by the commissioner. (V.T.I.C. Art. 21.53I, Sec. 5.)

6 Source Law

7 Sec. 5. A health benefit plan that provides
8 coverage under this article shall provide notice of
9 the availability of that coverage to each enrollee in
10 accordance with rules adopted by the commissioner.

11 Revised Law

12 Sec. 1357.007. RULES. The commissioner may adopt rules to
13 implement this subchapter and to meet the minimum requirements of
14 federal law. (V.T.I.C. Art. 21.53I, Sec. 7.)

15 Source Law

16 Sec. 7. The commissioner may adopt rules to
17 implement this article and to meet the minimum
18 requirements of federal law.

19 Revisor's Note
20 (End of Subchapter)

21 Section 6, V.T.I.C. Article 21.53I, states that
22 the article is severable. The revised law omits the
23 provision as unnecessary because it duplicates Section
24 311.032, Government Code (Code Construction Act),
25 applicable to the revised law, and Section 312.013,
26 Government Code. Those provisions state that a
27 provision of a statute is severable from each other
28 provision of the statute that can be given effect. The
29 omitted law reads:

30 Sec. 6. If any provision of this
31 article or the application of this article
32 to any person or circumstance is held
33 invalid, the invalidity does not affect a
34 provision or application of this article
35 that can be given effect without the invalid
36 provision or application, and to this end,
37 the provisions of this article are declared
38 to be severable.

39 [Sections 1357.008-1357.050 reserved for expansion]

1 SUBCHAPTER B. HOSPITAL STAY FOLLOWING MASTECTOMY AND CERTAIN
2 RELATED PROCEDURES

3 Revised Law

4 Sec. 1357.051. DEFINITION. In this subchapter, "enrollee"
5 means an individual entitled to coverage under a health benefit
6 plan. (V.T.I.C. Art. 21.52G, Sec. 1(1), as added Acts 75th Leg.,
7 R.S., Ch. 725.)

8 Source Law

9 Art. 21.52G

10 Sec. 1. In this article:

11 (1) "Enrollee" means a person entitled to
12 coverage under a health benefit plan.

13 Revisor's Note

14 Section 1(2), V.T.I.C. Article 21.52G, as added
15 by Chapter 725, Acts of the 75th Legislature, Regular
16 Session, 1997, defines "health benefit plan." The
17 revised law omits the definition as unnecessary
18 because Section 2 of that article, revised as Sections
19 1357.052 and 1357.053, specify the types of health
20 benefit plans to which this subchapter applies, and
21 thus the defined term is not helpful to the reader.

22 The omitted law reads:

23 (2) "Health benefit plan" means
24 a plan described by Section 2 of this
25 article.

26 Revised Law

27 Sec. 1357.052. APPLICABILITY OF SUBCHAPTER. This
28 subchapter applies only to a health benefit plan that:

29 (1) provides benefits for medical or surgical expenses
30 incurred as a result of a health condition, accident, or sickness,
31 including:

32 (A) an individual, group, blanket, or franchise
33 insurance policy or insurance agreement, a group hospital service
34 contract, or an individual or group evidence of coverage that is
35 offered by:

36 (i) an insurance company;

1 (ii) a group hospital service corporation
2 operating under Chapter 842;

3 (iii) a fraternal benefit society operating
4 under Chapter 885;

5 (iv) a stipulated premium company operating
6 under Chapter 884; or

7 (v) a health maintenance organization
8 operating under Chapter 843; and

9 (B) to the extent permitted by the Employee
10 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et
11 seq.), a health benefit plan that is offered by:

12 (i) a multiple employer welfare arrangement
13 as defined by Section 3 of that Act; or

14 (ii) another analogous benefit
15 arrangement;

16 (2) is offered by an approved nonprofit health
17 corporation that holds a certificate of authority under Chapter
18 844; or

19 (3) provides coverage only for a specific disease or
20 condition or for hospitalization. (V.T.I.C. Art. 21.52G, Secs.
21 2(a), (b), as added Acts 75th Leg., R.S., Ch. 725.)

22 Source Law

23 Sec. 2. (a) This article applies only to a
24 health benefit plan that:

25 (1) provides benefits for medical or
26 surgical expenses incurred as a result of a health
27 condition, accident, or sickness, including:

28 (A) an individual, group, blanket, or
29 franchise insurance policy or insurance agreement, a
30 group hospital service contract, or an individual or
31 group evidence of coverage that is offered by:

32 (i) an insurance company;
33 (ii) a group hospital service
34 corporation operating under Chapter 20 of this code;

35 (iii) a fraternal benefit
36 society operating under Chapter 10 of this code;

37 (iv) a stipulated premium
38 insurance company operating under Chapter 22 of this
39 code; or

40 (v) a health maintenance
41 organization operating under the Texas Health
42 Maintenance Organization Act (Chapter 20A, Vernon's
43 Texas Insurance Code); or

44 (B) to the extent permitted by the
45 Employee Retirement Income Security Act of 1974 (29

1 U.S.C. Section 1001 et seq.), a health benefit plan
2 that is offered by:

3 (i) a multiple employer welfare
4 arrangement as defined by Section 3, Employee
5 Retirement Income Security Act of 1974 (29 U.S.C.
6 Section 1002); or

7 (ii) another analogous benefit
8 arrangement; or

9 (2) is offered by an approved nonprofit
10 health corporation that is certified under Section
11 5.01(a), Medical Practice Act (Article 4495b, Vernon's
12 Texas Civil Statutes), and that holds a certificate of
13 authority issued by the commissioner under Article
14 21.52F of this code.

15 (b) This article applies to a health benefit
16 plan that provides coverage only for a specific
17 disease or condition or for hospitalization.

18 Revisor's Note

19 Section 2(a), V.T.I.C. Article 21.52G, as added
20 by Chapter 725, Acts of the 75th Legislature, Regular
21 Session, 1997, refers to an approved nonprofit health
22 corporation that is "certified under Section 5.01(a),
23 Medical Practice Act," and holds a certificate of
24 authority "issued by the commissioner under Article
25 21.52F." The revised law omits the reference to
26 certification under Section 5.01(a), Medical Practice
27 Act (Article 4495(b), Vernon's Texas Civil Statutes),
28 which was codified in 1999 in Chapter 162, Occupations
29 Code, as unnecessary because V.T.I.C. Article 21.52F,
30 revised as Chapter 844 of this code, requires a
31 nonprofit corporation to be certified under that
32 provision as a condition of holding a certificate of
33 authority. The revised law also omits as unnecessary
34 the reference to the commissioner issuing the
35 certificate of authority because Chapter 844 requires
36 the commissioner to issue the certificate of
37 authority.

38 Revised Law

39 Sec. 1357.053. EXCEPTION. This subchapter does not apply
40 to:

41 (1) a plan that provides coverage:

42 (A) only for accidental death or dismemberment;

1 (B) for wages or payments in lieu of wages for a
2 period during which an employee is absent from work because of
3 sickness or injury; or

4 (C) as a supplement to a liability insurance
5 policy;

6 (2) a small employer health benefit plan written under
7 Chapter 1501;

8 (3) a Medicare supplemental policy as defined by
9 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

10 (4) a workers' compensation insurance policy;

11 (5) medical payment insurance coverage provided under
12 a motor vehicle insurance policy; or

13 (6) a long-term care insurance policy, including a
14 nursing home fixed indemnity policy, unless the commissioner
15 determines that the policy provides benefit coverage so
16 comprehensive that the policy is a health benefit plan as described
17 by Section 1357.052. (V.T.I.C. Art. 21.52G, Sec. 2(c), as added
18 Acts 75th Leg., R.S., Ch. 725.)

19 Source Law

20 (c) This article does not apply to:

21 (1) a plan that provides coverage:

22 (A) only for accidental death or
23 dismemberment;

24 (B) for wages or payments in lieu of
25 wages for a period during which an employee is absent
26 from work because of sickness or injury; or

27 (C) as a supplement to liability
28 insurance;

29 (2) a small-employer plan written under
30 Chapter 26 of this code;

31 (3) a Medicare supplemental policy as
32 defined by Section 1882(g)(1), Social Security Act (42
33 U.S.C. 1395ss);

34 (4) workers' compensation insurance
35 coverage;

36 (5) medical payment insurance issued as
37 part of a motor vehicle insurance policy; or

38 (6) a long-term care policy, including a
39 nursing home fixed indemnity policy, unless the
40 commissioner determines that the policy provides
41 benefit coverage so comprehensive that the policy is a
42 health benefit plan as described by Subsection (a) of
43 this section.

44 Revised Law

45 Sec. 1357.054. COVERAGE REQUIRED. (a) A health benefit

1 plan that provides coverage for the treatment of breast cancer must
2 provide to each enrollee coverage for inpatient care for a minimum
3 of:

4 (1) 48 hours following a mastectomy; and

5 (2) 24 hours following a lymph node dissection for the
6 treatment of breast cancer.

7 (b) A health benefit plan is not required to provide the
8 minimum hours of coverage of inpatient care required under
9 Subsection (a) if the enrollee and the enrollee's attending
10 physician determine that a shorter period of inpatient care is
11 appropriate. (V.T.I.C. Art. 21.52G, Sec. 3, as added Acts 75th
12 Leg., R.S., Ch. 725.)

13 Source Law

14 Sec. 3. (a) A health benefit plan that
15 provides benefits for the treatment of breast cancer
16 must include coverage for inpatient care for an
17 enrollee for a minimum of:

18 (1) 48 hours following a mastectomy; and

19 (2) 24 hours following a lymph node
20 dissection for the treatment of breast cancer.

21 (b) A health benefit plan is not required to
22 provide the minimum hours of coverage of inpatient
23 care required under Subsection (a) of this section if
24 the enrollee and the enrollee's attending physician
25 determine that a shorter period of inpatient care is
26 appropriate.

27 Revised Law

28 Sec. 1357.055. PROHIBITED CONDUCT. An issuer of a health
29 benefit plan may not:

30 (1) deny the eligibility or continued eligibility of
31 an individual to enroll in the plan or renew coverage under the plan
32 solely to avoid the requirements of this subchapter;

33 (2) provide money payments or rebates to an enrollee
34 to encourage the enrollee to accept less than the minimum coverage
35 required under this subchapter;

36 (3) reduce or limit the amount paid to an attending
37 physician, or otherwise penalize the physician, because the
38 physician provided care to an enrollee in accordance with this
39 subchapter; or

40 (4) provide financial or other incentives to an

1 attending physician to encourage the physician to provide care to
2 an enrollee in a manner inconsistent with this subchapter.
3 (V.T.I.C. Art. 21.52G, Sec. 4, as added Acts 75th Leg., R.S., Ch.
4 725.)

5 Source Law

6 Sec. 4. The issuer of a health benefit plan may
7 not:

8 (1) deny to an enrollee eligibility or
9 continued eligibility to enroll or renew coverage
10 under the terms of the plan solely to avoid the
11 requirements of this article;

12 (2) provide money payments or rebates to
13 an enrollee to encourage the enrollee to accept less
14 than the minimum coverage required under Section 3(a)
15 of this article;

16 (3) reduce or limit the amount paid to an
17 attending physician, or otherwise penalize the
18 physician, because the physician provided care to an
19 enrollee in accordance with this article; or

20 (4) provide financial or other incentives
21 to an attending physician to encourage the physician
22 to provide care to an enrollee in a manner inconsistent
23 with this article.

24 Revised Law

25 Sec. 1357.056. NOTICE OF COVERAGE. (a) An issuer of a
26 health benefit plan shall provide to each enrollee written notice
27 of the coverage required under this subchapter.

28 (b) The notice must be provided in accordance with rules
29 adopted by the commissioner. (V.T.I.C. Art. 21.52G, Sec. 5, as
30 added Acts 75th Leg., R.S., Ch. 725.)

31 Source Law

32 Sec. 5. Each health benefit plan shall provide
33 written notice to each enrollee under the plan
34 regarding the coverage required by this article. The
35 notice must be provided in accordance with rules
36 adopted by the commissioner.

37 Revised Law

38 Sec. 1357.057. RULES. The commissioner shall adopt rules
39 necessary to administer this subchapter. (V.T.I.C. Art. 21.52G,
40 Sec. 6, as added Acts 75th Leg., R.S., Ch. 725.)

41 Source Law

42 Sec. 6. The commissioner shall adopt rules as
43 necessary to administer this article.

1 CHAPTER 1358. DIABETES

2 SUBCHAPTER A. GUIDELINES FOR DIABETES CARE;

3 MINIMUM COVERAGE REQUIRED

4 Sec. 1358.001. DEFINITION 941

5 Sec. 1358.002. APPLICABILITY OF SUBCHAPTER 942

6 Sec. 1358.003. EXCEPTION. 943

7 Sec. 1358.004. ADOPTION OF MINIMUM STANDARDS 945

8 Sec. 1358.005. COVERAGE REQUIRED 945

9 [Sections 1358.006-1358.050 reserved for expansion]

10 SUBCHAPTER B. SUPPLIES AND SERVICES ASSOCIATED

11 WITH DIABETES TREATMENT

12 Sec. 1358.051. DEFINITIONS 946

13 Sec. 1358.052. APPLICABILITY OF SUBCHAPTER 948

14 Sec. 1358.053. EXCEPTION. 950

15 Sec. 1358.054. COVERAGE REQUIRED 951

16 Sec. 1358.055. DIABETES SELF-MANAGEMENT TRAINING. 952

17 Sec. 1358.056. COVERAGE FOR NEW OR IMPROVED EQUIPMENT

18 AND SUPPLIES 956

19 Sec. 1358.057. RULES 956

20 CHAPTER 1358. DIABETES

21 SUBCHAPTER A. GUIDELINES FOR DIABETES CARE;

22 MINIMUM COVERAGE REQUIRED

23 Revised Law

24 Sec. 1358.001. DEFINITION. In this subchapter, "enrollee"

25 means an individual entitled to coverage under a health benefit

26 plan. (V.T.I.C. Art. 21.53D, Sec. 1(1), as added Acts 75th Leg.,

27 R.S., Ch. 1285.)

28 Source Law

29 Art. 21.53D

30 Sec. 1. In this article:

31 (1) "Enrollee" means a person entitled to

32 coverage under a health benefit plan.

33 Revisor's Note

34 Section 1(2), V.T.I.C. Article 21.53D, as added

35 by Chapter 1285, Acts of the 75th Legislature, Regular

1 Session, 1997, defines "health benefit plan." The
2 revised law omits the definition as unnecessary
3 because Section 2 of that article, revised as Sections
4 1358.002 and 1358.003, specifies the types of health
5 benefit plans to which this subchapter applies, and
6 thus the defined term is not helpful to the reader. The
7 omitted law reads:

8 (2) "Health benefit plan" means
9 a plan described by Section 2 of this
10 article.

11 Revised Law

12 Sec. 1358.002. APPLICABILITY OF SUBCHAPTER. This
13 subchapter applies only to a health benefit plan that provides
14 benefits for medical or surgical expenses incurred as a result of a
15 health condition, accident, or sickness, including:

16 (1) an individual, group, blanket, or franchise
17 insurance policy or insurance agreement, a group hospital service
18 contract, or an individual or group evidence of coverage that is
19 offered by:

20 (A) an insurance company;

21 (B) a group hospital service corporation
22 operating under Chapter 842;

23 (C) a fraternal benefit society operating under
24 Chapter 885;

25 (D) a stipulated premium company operating under
26 Chapter 884; or

27 (E) a health maintenance organization operating
28 under Chapter 843;

29 (2) to the extent permitted by the Employee Retirement
30 Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.), a
31 health benefit plan that is offered by:

32 (A) a multiple employer welfare arrangement as
33 defined by Section 3 of that Act; or

34 (B) another analogous benefit arrangement; and

35 (3) health and accident coverage provided by a risk

1 pool created under Chapter 172, Local Government Code,
2 notwithstanding Section 172.014, Local Government Code, or any
3 other law. (V.T.I.C. Art. 21.53D, Sec. 2(a), as added Acts 75th
4 Leg., R.S., Ch. 1285.)

5 Source Law

6 Sec. 2. (a) This article applies only to a
7 health benefit plan that provides benefits for medical
8 or surgical expenses incurred as a result of a health
9 condition, accident, or sickness, including:

10 (1) an individual, group, blanket, or
11 franchise insurance policy or insurance agreement, a
12 group hospital service contract, or an individual or
13 group evidence of coverage that is offered by:

- 14 (A) an insurance company;
15 (B) a group hospital service
16 corporation operating under Chapter 20 of this code;
17 (C) a fraternal benefit society
18 operating under Chapter 10 of this code;
19 (D) a stipulated premium insurance
20 company operating under Chapter 22 of this code; or
21 (E) a health maintenance
22 organization operating under the Texas Health
23 Maintenance Organization Act (Chapter 20A, Vernon's
24 Texas Insurance Code);

25 (2) to the extent permitted by the
26 Employee Retirement Income Security Act of 1974 (29
27 U.S.C. Section 1001 et seq.), a health benefit plan
28 that is offered by:

29 (A) a multiple employer welfare
30 arrangement as defined by Section 3, Employee
31 Retirement Income Security Act of 1974 (29 U.S.C.
32 Section 1002); or

33 (B) another analogous benefit
34 arrangement; or

35 (3) notwithstanding Section 172.014,
36 Local Government Code, or any other law, health and
37 accident coverage provided by a risk pool created
38 under Chapter 172, Local Government Code.

39 Revised Law

40 Sec. 1358.003. EXCEPTION. This subchapter does not apply
41 to:

42 (1) a plan that provides coverage:

43 (A) only for a specified disease;

44 (B) only for accidental death or dismemberment;

45 (C) for wages or payments in lieu of wages for a
46 period during which an employee is absent from work because of
47 sickness or injury;

48 (D) as a supplement to a liability insurance
49 policy;

50 (E) only for dental or vision care; or

- 1 (F) only for indemnity for hospital confinement;
2 (2) a small employer health benefit plan written under
3 Chapter 1501;
4 (3) a Medicare supplemental policy as defined by
5 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
6 (4) a workers' compensation insurance policy;
7 (5) medical payment insurance coverage provided under
8 a motor vehicle insurance policy; or
9 (6) a long-term care insurance policy, including a
10 nursing home fixed indemnity policy, unless the commissioner
11 determines that the policy provides benefit coverage so
12 comprehensive that the policy is a health benefit plan as described
13 by Section 1358.002. (V.T.I.C. Art. 21.53D, Sec. 2(b), as added
14 Acts 75th Leg., R.S., Ch. 1285.)

15 Source Law

- 16 (b) This article does not apply to:
17 (1) a plan that provides coverage:
18 (A) only for a specified disease;
19 (B) only for accidental death or
20 dismemberment;
21 (C) for wages or payments in lieu of
22 wages for a period during which an employee is absent
23 from work because of sickness or injury;
24 (D) as a supplement to liability
25 insurance;
26 (E) dental or vision care only; or
27 (F) hospital confinement indemnity
28 coverage only;
29 (2) a plan written under Chapter 26 of this
30 code;
31 (3) a Medicare supplemental policy as
32 defined by Section 1882(g)(1), Social Security Act (42
33 U.S.C. Section 1395ss);
34 (4) workers' compensation insurance
35 coverage;
36 (5) medical payment insurance issued as
37 part of a motor vehicle insurance policy; or
38 (6) a long-term care policy, including a
39 nursing home fixed indemnity policy, unless the
40 commissioner determines that the policy provides
41 benefit coverage so comprehensive that the policy is a
42 health benefit plan as described by Subsection (a) of
43 this section.

44 Revisor's Note

45 Section 2(b)(2), V.T.I.C. Article 21.53D, as
46 added by Chapter 1285, Acts of the 75th Legislature,
47 Regular Session, 1997, refers to "a plan written under

1 Chapter 26 of this code." The revised law refers to a
2 "small employer health benefit plan written under
3 Chapter 1501." When Article 21.53D was enacted,
4 Chapter 26, codified as Chapter 1501 of this code,
5 addressed only benefit plans offered by small
6 employers. Provisions addressing benefit plans
7 offered by large employers were later added to Chapter
8 26 through the enactment of Chapter 955, Acts of the
9 75th Legislature, Regular Session, 1997.
10 Consequently, the reference to a "small employer
11 health benefit plan" correctly reflects legislative
12 intent.

13 Revised Law

14 Sec. 1358.004. ADOPTION OF MINIMUM STANDARDS. The
15 commissioner, in consultation with the Texas Diabetes Council, by
16 rule shall adopt minimum standards for coverage provided to an
17 enrollee with diabetes. (V.T.I.C. Art. 21.53D, Sec. 3(a), as added
18 Acts 75th Leg., R.S., Ch. 1285.)

19 Source Law

20 Sec. 3. (a) The commissioner, in consultation
21 with the Texas Diabetes Council, shall by rule adopt
22 minimum standards for benefits provided to enrollees
23 with diabetes.

24 Revised Law

25 Sec. 1358.005. COVERAGE REQUIRED. (a) A health benefit
26 plan must provide coverage in accordance with the standards adopted
27 under Section 1358.004.

28 (b) Coverage required under this section may not be subject
29 to a deductible, coinsurance, or copayment requirement that exceeds
30 the deductible, coinsurance, or copayment requirement applicable
31 to other similar coverage provided under the health benefit plan.
32 (V.T.I.C. Art. 21.53D, Secs. 3(b), (c), as added Acts 75th Leg.,
33 R.S., Ch. 1285.)

34 Source Law

35 (b) Each health care benefit plan shall provide
36 benefits for the care required by the minimum

1 standards adopted under Subsection (a) of this
2 section.

3 (c) The benefits required under this article may
4 not be subject to a deductible, coinsurance, or
5 copayment requirement that exceeds the applicable
6 deductible, coinsurance, or copayment applicable to
7 other similar benefits provided under the plan.

8 [Sections 1358.006-1358.050 reserved for expansion]

9 SUBCHAPTER B. SUPPLIES AND SERVICES ASSOCIATED

10 WITH DIABETES TREATMENT

11 Revised Law

12 Sec. 1358.051. DEFINITIONS. In this subchapter:

13 (1) "Diabetes equipment" means:

14 (A) blood glucose monitors, including monitors
15 designed to be used by blind individuals;

16 (B) insulin pumps and associated appurtenances;

17 (C) insulin infusion devices; and

18 (D) podiatric appliances for the prevention of
19 complications associated with diabetes.

20 (2) "Diabetes supplies" means:

21 (A) test strips for blood glucose monitors;

22 (B) visual reading and urine test strips;

23 (C) lancets and lancet devices;

24 (D) insulin and insulin analogs;

25 (E) injection aids;

26 (F) syringes;

27 (G) prescriptive and nonprescriptive oral agents
28 for controlling blood sugar levels; and

29 (H) glucagon emergency kits.

30 (3) "Nutrition counseling" has the meaning assigned by
31 Section 701.002, Occupations Code.

32 (4) "Qualified enrollee" means an individual eligible
33 for coverage under a health benefit plan who has been diagnosed
34 with:

35 (A) insulin dependent or noninsulin dependent
36 diabetes;

37 (B) elevated blood glucose levels induced by

1 pregnancy; or

2 (C) another medical condition associated with
3 elevated blood glucose levels. (V.T.I.C. Art. 21.53G, Secs. 1(1),
4 (2), (4), (5).)

5 Source Law

6 Art. 21.53G

7 Sec. 1. In this article:

8 (1) "Diabetes equipment" means:

9 (A) blood glucose monitors,
10 including monitors designed to be used by blind
11 individuals;

12 (B) insulin pumps and associated
13 appurtenances;

14 (C) insulin infusion devices; and

15 (D) podiatric appliances for the
16 prevention of complications associated with diabetes.

17 (2) "Diabetes supplies" means:

18 (A) test strips for blood glucose
19 monitors;

20 (B) visual reading and urine test
21 strips;

22 (C) lancets and lancet devices;

23 (D) insulin and insulin analogs;

24 (E) injection aids;

25 (F) syringes;

26 (G) prescriptive and nonprescriptive
27 oral agents for controlling blood sugar levels; and

28 (H) glucagon emergency kits.

29 (4) "Qualified insured" means an
30 individual eligible for coverage under a health
31 benefit plan who has been diagnosed with:

32 (A) insulin dependent or noninsulin
33 dependent diabetes;

34 (B) elevated blood glucose levels
35 induced by pregnancy; or

36 (C) another medical condition
37 associated with elevated blood glucose levels.

38 (5) "Nutrition counseling" has the meaning
39 assigned by Section 2, Licensed Dietitian Act (Article
40 4512h, Vernon's Texas Civil Statutes).

41 Revisor's Note

42 (1) Section 1(3), V.T.I.C. Article 21.53G,
43 defines "health benefit plan." The revised law omits
44 the definition as unnecessary because Section 2 of
45 that article, revised as Sections 1358.052 and
46 1358.053, specifies the types of health benefit plans
47 to which this subchapter applies, and thus the defined
48 term is not helpful to the reader. The omitted law
49 reads:

50 (3) "Health benefit plan" means
51 a plan described by Section 2 of this

1 article.

2 (2) Section 1(4), V.T.I.C. Article 21.53G,
3 defines "qualified insured" to include certain
4 individuals eligible for coverage under a health
5 benefit plan. "Insured" is a term used in conjunction
6 with traditional insurance. This subchapter applies
7 to health benefit plans offered by entities such as
8 health maintenance organizations that are not
9 traditional insurers. Consequently, "enrollee" is a
10 more accurate term than "insured," and the revised law
11 substitutes "enrollee" for "insured."

12 (3) Section 1(5), V.T.I.C. Article 21.53G,
13 refers to Section 2, Licensed Dietitian Act (Article
14 4512h, Vernon's Texas Civil Statutes). That statute
15 was codified in 1999 as Section 701.002, Occupations
16 Code. The revised law is drafted accordingly.

17 Revised Law

18 Sec. 1358.052. APPLICABILITY OF SUBCHAPTER. This
19 subchapter applies only to a health benefit plan that:

20 (1) provides benefits for medical or surgical expenses
21 incurred as a result of a health condition, accident, or sickness,
22 including:

23 (A) an individual, group, blanket, or franchise
24 insurance policy or insurance agreement, a group hospital service
25 contract, or an individual or group evidence of coverage that is
26 offered by:

- 27 (i) an insurance company;
- 28 (ii) a group hospital service corporation
29 operating under Chapter 842;
- 30 (iii) a fraternal benefit society operating
31 under Chapter 885;
- 32 (iv) a stipulated premium company operating
33 under Chapter 884;
- 34 (v) a reciprocal exchange operating under

1 Chapter 942; or

2 (vi) a health maintenance organization
3 operating under Chapter 843; and

4 (B) to the extent permitted by the Employee
5 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et
6 seq.), a health benefit plan that is offered by a multiple employer
7 welfare arrangement as defined by Section 3 of that Act; or

8 (2) is offered by an approved nonprofit health
9 corporation that holds a certificate of authority under Chapter
10 844. (V.T.I.C. Art. 21.53G, Sec. 2(a).)

11 Source Law

12 Sec. 2. (a) This article applies to a health
13 benefit plan that:

14 (1) provides benefits for medical or
15 surgical expenses incurred as a result of a health
16 condition, accident, or sickness, including:

17 (A) an individual, group, blanket, or
18 franchise insurance policy or insurance agreement, a
19 group hospital service contract, or an individual or
20 group evidence of coverage that is offered by:

21 (i) an insurance company;

22 (ii) a group hospital service
23 corporation operating under Chapter 20 of this code;

24 (iii) a fraternal benefit
25 society operating under Chapter 10 of this code;

26 (iv) a stipulated premium
27 insurance company operating under Chapter 22 of this
28 code;

29 (v) a reciprocal exchange
30 operating under Chapter 19 of this code; or

31 (vi) a health maintenance
32 organization operating under the Texas Health
33 Maintenance Organization Act (Chapter 20A, Vernon's
34 Texas Insurance Code); or

35 (B) to the extent permitted by the
36 Employee Retirement Income Security Act of 1974 (29
37 U.S.C. Section 1001 et seq.), a health benefit plan
38 that is offered by a multiple employer welfare
39 arrangement as defined by Section 3, Employee
40 Retirement Income Security Act of 1974 (29 U.S.C.
41 Section 1002); or

42 (2) is offered by an approved nonprofit
43 health corporation that is certified under Section
44 5.01(a), Medical Practice Act (Article 4495b, Vernon's
45 Texas Civil Statutes), and that holds a certificate of
46 authority issued by the commissioner under Article
47 21.52F of this code.

48 Revisor's Note

49 Section 2(a)(2), V.T.I.C. Article 21.53G, refers
50 to an approved nonprofit health corporation that is
51 "certified under Section 5.01(a), Medical Practice

1 Act," and holds a certificate of authority "issued by
2 the commissioner under Article 21.52F." The revised
3 law omits the reference to certification under Section
4 5.01(a), Medical Practice Act (Article 4495b, Vernon's
5 Texas Civil Statutes), which was codified in 1999 in
6 Chapter 162, Occupations Code, as unnecessary because
7 V.T.I.C. Article 21.52F, revised as Chapter 844 of
8 this code, requires a nonprofit corporation to be
9 certified under that provision as a condition of
10 holding a certificate of authority. The revised law
11 also omits as unnecessary the reference to the
12 commissioner issuing the certificate of authority
13 because Chapter 844 requires the commissioner to issue
14 the certificate of authority.

15 Revised Law

16 Sec. 1358.053. EXCEPTION. This subchapter does not apply
17 to:

- 18 (1) a plan that provides coverage:
- 19 (A) only for a specified disease or another
20 limited benefit;
 - 21 (B) only for accidental death or dismemberment;
 - 22 (C) for wages or payments in lieu of wages for a
23 period during which an employee is absent from work because of
24 sickness or injury;
 - 25 (D) as a supplement to a liability insurance
26 policy;
 - 27 (E) for credit insurance;
 - 28 (F) only for dental or vision care; or
 - 29 (G) only for indemnity for hospital confinement;
- 30 (2) a small employer health benefit plan written under
31 Chapter 1501;
- 32 (3) a Medicare supplemental policy as defined by
33 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
- 34 (4) a workers' compensation insurance policy;

1 (5) medical payment insurance coverage provided under
2 a motor vehicle insurance policy; or

3 (6) a long-term care insurance policy, including a
4 nursing home fixed indemnity policy, unless the commissioner
5 determines that the policy provides benefit coverage so
6 comprehensive that the policy is a health benefit plan as described
7 by Section 1358.052. (V.T.I.C. Art. 21.53G, Sec. 2(b).)

8 Source Law

9 (b) This article does not apply to:

10 (1) a plan that provides coverage:

11 (A) only for a specified disease or
12 other limited benefit;

13 (B) only for accidental death or
14 dismemberment;

15 (C) for wages or payments in lieu of
16 wages for a period during which an employee is absent
17 from work because of sickness or injury;

18 (D) as a supplement to liability
19 insurance;

20 (E) for credit insurance;

21 (F) only for dental or vision care;

22 or

23 (G) only for indemnity for hospital
24 confinement;

25 (2) a small employer plan written under
26 Chapter 26 of this code;

27 (3) a Medicare supplemental policy as
28 defined by Section 1882(g)(1), Social Security Act (42
29 U.S.C. Section 1395ss);

30 (4) workers' compensation insurance
31 coverage;

32 (5) medical payment insurance issued as
33 part of a motor vehicle insurance policy; or

34 (6) a long-term care policy, including a
35 nursing home fixed indemnity policy, unless the
36 commissioner determines that the policy provides
37 benefit coverage so comprehensive that the policy is a
38 health benefit plan as described by Subsection (a) of
39 this section.

40 Revised Law

41 Sec. 1358.054. COVERAGE REQUIRED. (a) A health benefit
42 plan that provides coverage for the treatment of diabetes and
43 conditions associated with diabetes must provide to each qualified
44 enrollee coverage for:

45 (1) diabetes equipment;

46 (2) diabetes supplies; and

47 (3) diabetes self-management training in accordance
48 with the requirements of Section 1358.055.

49 (b) A health benefit plan may require a deductible,

1 copayment, or coinsurance for coverage provided under this section.
2 The amount of the deductible, copayment, or coinsurance may not
3 exceed the amount of the deductible, copayment, or coinsurance
4 required for treatment of other analogous chronic medical
5 conditions. (V.T.I.C. Art. 21.53G, Secs. 3, 6.)

6 Source Law

7 Sec. 3. A health benefit plan that provides
8 benefits for the treatment of diabetes and associated
9 conditions must provide coverage to each qualified
10 insured for:

- 11 (1) diabetes equipment;
- 12 (2) diabetes supplies; and
- 13 (3) diabetes self-management training
14 programs.

15 Sec. 6. Benefits required under this article may
16 be made subject to a deductible, copayment, or
17 coinsurance requirement. A deductible, copayment, or
18 coinsurance required by the health benefit plan for
19 benefits under this article may not exceed the
20 deductible, copayment, or coinsurance required by the
21 health benefit plan for treatment of other analogous
22 chronic medical conditions.

23 Revised Law

24 Sec. 1358.055. DIABETES SELF-MANAGEMENT TRAINING. (a)
25 Diabetes self-management training must be provided by a health care
26 practitioner or provider who is:

- 27 (1) licensed, registered, or certified in this state
28 to provide appropriate health care services; and
- 29 (2) acting within the scope of practice authorized by
30 the license, registration, or certification.

31 (b) For purposes of this subchapter, "self-management
32 training" includes:

- 33 (1) training provided to a qualified enrollee, after
34 the initial diagnosis of diabetes, in the care and management of
35 that condition, including nutrition counseling and counseling on
36 the proper use of diabetes equipment and supplies;
- 37 (2) additional training authorized on the diagnosis of
38 a physician or other health care practitioner of a significant
39 change in the qualified enrollee's symptoms or condition that
40 requires changes in the qualified enrollee's self-management
41 regime; and

1 (3) periodic or episodic continuing education
2 training prescribed by an appropriate health care practitioner as
3 warranted by the development of new techniques or treatments for
4 diabetes.

5 (c) If the diabetes self-management training is provided on
6 the written order of a physician or other health care practitioner,
7 including a health care practitioner practicing under protocols
8 jointly developed with a physician, the training must also include:

9 (1) a diabetes self-management training program
10 recognized by the American Diabetes Association;

11 (2) diabetes self-management training provided by a
12 multidisciplinary team:

13 (A) the nonphysician members of which are
14 coordinated by:

15 (i) a diabetes educator who is certified by
16 the National Certification Board for Diabetes Educators; or

17 (ii) an individual who has completed at
18 least 24 hours of continuing education that meets guidelines
19 established by the Texas Board of Health and that includes a
20 combination of diabetes-related educational principles and
21 behavioral strategies;

22 (B) that consists of at least a licensed
23 dietitian and a registered nurse and may include a pharmacist and a
24 social worker; and

25 (C) each member of which, other than a social
26 worker, has recent didactic and experiential preparation in
27 diabetes clinical and educational issues as determined by the
28 member's licensing agency, in consultation with the commissioner of
29 public health, unless the member's licensing agency, in
30 consultation with the commissioner of public health, determines
31 that the core educational preparation for the member's license
32 includes the skills the member needs to provide diabetes
33 self-management training;

34 (3) diabetes self-management training provided by a

1 diabetes educator certified by the National Certification Board for
2 Diabetes Educators; or

3 (4) diabetes self-management training that provides
4 one or more of the following components:

5 (A) a nutrition counseling component provided by
6 a licensed dietitian, for which the licensed dietitian shall be
7 paid;

8 (B) a pharmaceutical component provided by a
9 pharmacist, for which the pharmacist shall be paid;

10 (C) a component provided by a physician assistant
11 or registered nurse, for which the physician assistant or
12 registered nurse shall be paid, except that the physician assistant
13 or registered nurse may not be paid for providing a nutrition
14 counseling or pharmaceutical component unless a licensed dietitian
15 or pharmacist is unavailable to provide that component; or

16 (D) a component provided by a physician.

17 (d) An individual may not provide a component of diabetes
18 self-management training under Subsection (c)(4) unless:

19 (1) the subject matter of the component is within the
20 scope of the individual's practice; and

21 (2) the individual meets the education requirements,
22 as determined by the individual's licensing agency in consultation
23 with the commissioner of public health. (V.T.I.C. Art. 21.53G,
24 Sec. 4.)

25 Source Law

26 Sec. 4. (a) Diabetes self-management training
27 under this article must be provided by a health care
28 practitioner or provider who is licensed, registered,
29 or certified in this state to provide appropriate
30 health care services and who is acting within the scope
31 of practice authorized by the practitioner's or
32 provider's license, registration, or certification.
33 Self-management training includes:

34 (1) training provided to a qualified
35 insured after the initial diagnosis of diabetes in the
36 care and management of that condition, including
37 nutrition counseling and proper use of diabetes
38 equipment and supplies;

39 (2) additional training authorized on the
40 diagnosis of a physician or other health care
41 practitioner of a significant change in the qualified
42 insured's symptoms or condition that requires changes

1 in the qualified insured's self-management regime; and
2 (3) periodic or episodic continuing
3 education training when prescribed by an appropriate
4 health care practitioner as warranted by the
5 development of new techniques and treatments for
6 diabetes.

7 (b) Coverage for diabetes self-management
8 training provided by a health benefit plan under this
9 article to a qualified insured must include coverage
10 for the following, if provided on the written order of
11 a physician or health care practitioner, including the
12 written order of a health care practitioner practicing
13 under protocols jointly developed with a physician:

14 (1) a diabetes self-management training
15 program recognized by the American Diabetes
16 Association;

17 (2) diabetes self-management training
18 given by a multidisciplinary team:

19 (A) the non-physician members of
20 which are coordinated by:

21 (i) a diabetes educator who is
22 certified by the National Certification Board for
23 Diabetes Educators; or

24 (ii) a person who has completed
25 at least 24 hours of continuing education that meets
26 guidelines established by the Texas Board of Health
27 and that includes a combination of diabetes-related
28 educational principles and behavioral strategies;

29 (B) that consists of at least a
30 licensed dietitian and a registered nurse and may
31 include a pharmacist and a social worker; and

32 (C) each member of which, other than
33 a social worker, has recent didactic and experiential
34 preparation in diabetes clinical and educational
35 issues as determined by the member's licensing agency,
36 in consultation with the commissioner of public
37 health, unless the member's licensing agency, in
38 consultation with the commissioner of public health,
39 determines that the core educational preparation for
40 the member's license includes the skills the member
41 needs to provide diabetes self-management training;

42 (3) diabetes self-management training
43 provided by a diabetes educator certified by the
44 National Certification Board for Diabetes Educators;
45 or

46 (4) diabetes self-management training in
47 which one or more of the following components are
48 provided:

49 (A) the nutrition counseling
50 component provided by a licensed dietitian, for which
51 the licensed dietitian shall be paid;

52 (B) the pharmaceutical component
53 provided by a pharmacist, for which the pharmacist
54 shall be paid;

55 (C) any component of the training
56 provided by a physician assistant or registered nurse,
57 for which the physician assistant or registered nurse
58 shall be paid, except that the physician assistant or
59 registered nurse may not be paid for providing a
60 nutrition counseling or pharmaceutical component
61 unless a licensed dietitian or pharmacist is
62 unavailable to provide that component; or

63 (D) any component of the training
64 provided by a physician.

65 (c) A person may not provide a component of
66 diabetes self-management training under Subsection
67 (b)(4) of this section unless the subject matter of the
68 component is within the scope of the person's practice

1 and the person meets the education requirements, as
2 determined by the person's licensing agency, in
3 consultation with the commissioner of public health.

4 Revised Law

5 Sec. 1358.056. COVERAGE FOR NEW OR IMPROVED EQUIPMENT AND
6 SUPPLIES. A health benefit plan must provide coverage for new or
7 improved diabetes equipment or supplies, including improved
8 insulin or another prescription drug, approved by the United States
9 Food and Drug Administration if the equipment or supplies are
10 determined by a physician or other health care practitioner to be
11 medically necessary and appropriate. (V.T.I.C. Art. 21.53G, Sec.
12 5.)

13 Source Law

14 Sec. 5. In addition to the benefits required
15 under Sections 3 and 4 of this article, on the approval
16 of the United States Food and Drug Administration of
17 new or improved diabetes equipment or diabetes
18 supplies, including improved insulin or other
19 prescription drugs, each health benefit plan subject
20 to this article must include coverage of the new or
21 improved equipment or supplies if medically necessary
22 and appropriate as determined by a physician or other
23 health care practitioner.

24 Revised Law

25 Sec. 1358.057. RULES. (a) The commissioner shall adopt
26 rules necessary to implement this subchapter.

27 (b) In adopting rules under this section, the commissioner
28 may consult with the commissioner of public health and other
29 appropriate entities. (V.T.I.C. Art. 21.53G, Sec. 7.)

30 Source Law

31 Sec. 7. The commissioner shall adopt rules as
32 necessary for the implementation of this article. The
33 commissioner may consult with the commissioner of
34 public health and other appropriate entities in
35 adopting rules under this section.

36 CHAPTER 1359. FORMULAS FOR INDIVIDUALS WITH
37 PHENYLKETONURIA OR OTHER HERITABLE DISEASES

38	Sec. 1359.001. DEFINITIONS	957
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1 CHAPTER 1359. FORMULAS FOR INDIVIDUALS WITH
2 PHENYLKETONURIA OR OTHER HERITABLE DISEASES

3 Revised Law

4 Sec. 1359.001. DEFINITIONS. In this chapter:

5 (1) "Heritable disease" means an inherited disease
6 that may result in mental or physical retardation or death.

7 (2) "Phenylketonuria" means an inherited condition
8 that, if not treated, may cause severe mental retardation.

9 (V.T.I.C. Art. 3.79, Secs. 1(2), (3).)

10 Source Law

11 Sec. 1. In this article:

12 (2) "Heritable disease" means an inherited
13 disease that may result in mental or physical
14 retardation or death.

15 (3) "Phenylketonuria" means an inherited
16 condition that may cause severe mental retardation if
17 not treated.

18 Revised Law

19 Sec. 1359.002. APPLICABILITY OF CHAPTER. This chapter
20 applies only to a group health benefit plan that is a group policy,
21 contract, or certificate of health insurance or an evidence of
22 coverage delivered, issued for delivery, or renewed in this state
23 by:

24 (1) an insurance company;

25 (2) a group hospital service corporation operating
26 under Chapter 842; or

27 (3) a health maintenance organization operating under
28 Chapter 843. (V.T.I.C. Art. 3.79, Sec. 1(1).)

29 Source Law

30 Art. 3.79

31 Sec. 1. In this article:

32 (1) "Health insurance policy" means any
33 group policy, contract, or certificate of health
34 insurance or evidence of coverage delivered, issued
35 for delivery, or renewed in this state by an insurance
36 company, including a group hospital service
37 corporation under Chapter 20 of this code and a health
38 maintenance organization under the Texas Health
39 Maintenance Organization Act (Chapter 20A, Vernon's
40 Texas Insurance Code).

1 Revisor's Note

2 Section 1(1), V.T.I.C. Article 3.79, defines
3 "health insurance policy." "Insurance policy" is a
4 term used in conjunction with traditional insurance.
5 Included in the definition of "health insurance
6 policy" are evidences of coverage issued by health
7 maintenance organizations. The coverage provided by
8 this type of document is not insurance coverage, and
9 this type of coverage document is not typically
10 described as an "insurance policy." Therefore, "group
11 health benefit plan" is a more accurate term than
12 "health insurance policy," and the revised law
13 substitutes "group health benefit plan" for "health
14 insurance policy."

15 Revised Law

16 Sec. 1359.003. COVERAGE REQUIRED. (a) A group health
17 benefit plan must provide coverage for formulas necessary to treat
18 phenylketonuria or a heritable disease.

19 (b) The group health benefit plan must provide the coverage
20 to the same extent that the plan provides coverage for drugs that
21 are available only on the orders of a physician. (V.T.I.C.
22 Art. 3.79, Sec. 2.)

23 Source Law

24 Sec. 2. Each health insurance policy shall
25 include coverage for formulas necessary for the
26 treatment of phenylketonuria or other heritable
27 diseases to the same extent as for drugs available only
28 on the orders of a physician.

29 CHAPTER 1360. DIAGNOSIS AND TREATMENT

30 AFFECTING TEMPOROMANDIBULAR JOINT

31 Sec. 1360.001. DEFINITION 959
32 Sec. 1360.002. APPLICABILITY OF CHAPTER 959
33 Sec. 1360.003. EXCEPTION. 961
34 Sec. 1360.004. COVERAGE REQUIRED 963
35 Sec. 1360.005. DENTAL SERVICES COVERAGE NOT REQUIRED. 963

1 CHAPTER 1360. DIAGNOSIS AND TREATMENT
2 AFFECTING TEMPOROMANDIBULAR JOINT

3 Revised Law

4 Sec. 1360.001. DEFINITION. In this chapter,
5 "temporomandibular joint" includes the jaw and the
6 craniomandibular joint. (V.T.I.C. Art. 21.53A, Sec. 3(a) (part).)

7 Source Law

8 (a) . . . For purposes of this section, the
9 temporomandibular joint includes the jaw and the
10 craniomandibular joint.

11 Revised Law

12 Sec. 1360.002. APPLICABILITY OF CHAPTER. This chapter
13 applies only to a group health benefit plan delivered or issued for
14 delivery in this state that:

15 (1) provides benefits for dental, medical, or surgical
16 expenses incurred as a result of a health condition, accident, or
17 sickness, including:

18 (A) a group, blanket, or franchise insurance
19 policy or insurance agreement, a group hospital service contract,
20 or a group evidence of coverage that is offered by:

- 21 (i) an insurance company;
22 (ii) a group hospital service corporation
23 operating under Chapter 842;
24 (iii) a fraternal benefit society operating
25 under Chapter 885;
26 (iv) a stipulated premium company operating
27 under Chapter 884; or
28 (v) a health maintenance organization
29 operating under Chapter 843; and

30 (B) to the extent permitted by the Employee
31 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et
32 seq.), a health benefit plan that is offered by:

- 33 (i) a multiple employer welfare arrangement
34 as defined by Section 3 of that Act;
35 (ii) an entity not authorized under this

1 code or another insurance law of this state that contracts directly
2 for health care services on a risk-sharing basis, including a
3 capitation basis; or

4 (iii) another analogous benefit
5 arrangement; or

6 (2) is offered by an approved nonprofit health
7 corporation that holds a certificate of authority under Chapter
8 844. (V.T.I.C. Art. 21.53A, Secs. 2(a), 3(a) (part).)

9 Source Law

10 Sec. 2. (a) This article applies to a group
11 health benefit plan that:

12 (1) provides benefits for dental, medical,
13 or surgical expenses incurred as a result of a health
14 condition, accident, or sickness, including:

15 (A) a group, blanket, or franchise
16 insurance policy or insurance agreement, a group
17 hospital service contract, or a group evidence of
18 coverage that is offered by:

19 (i) an insurance company;

20 (ii) a group hospital service
21 corporation operating under Chapter 20 of this code;

22 (iii) a fraternal benefit
23 society operating under Chapter 10 of this code;

24 (iv) a stipulated premium
25 insurance company operating under Chapter 22 of this
26 code; or

27 (v) a health maintenance
28 organization operating under the Texas Health
29 Maintenance Organization Act (Chapter 20A, Vernon's
30 Texas Insurance Code); or

31 (B) to the extent permitted by the
32 Employee Retirement Income Security Act of 1974 (29
33 U.S.C. Section 1001 et seq.), a health benefit plan
34 that is offered by:

35 (i) a multiple employer welfare
36 arrangement as defined by Section 3, Employee
37 Retirement Income Security Act of 1974 (29 U.S.C.
38 Section 1002);

39 (ii) any other entity not
40 licensed under this code or another insurance law of
41 this state that contracts directly for health care
42 services on a risk-sharing basis, including an entity
43 that contracts for health care services on a
44 capitation basis; or

45 (iii) another analogous benefit
46 arrangement; or

47 (2) is offered by an approved nonprofit
48 health corporation that is certified under Section
49 5.01(a), Medical Practice Act (Article 4495b, Vernon's
50 Texas Civil Statutes), and that holds a certificate of
51 authority issued by the commissioner under Article
52 21.52F of this code.

53 Sec. 3. (a) Each health benefit plan delivered
54 or issued for delivery in this state

1 Revisor's Note

2 (1) Section 2(a), V.T.I.C. Article 21.53A,
3 refers to a health benefit plan offered by an entity
4 that is not "licensed" under the Insurance Code or
5 another insurance law of this state. The revised law
6 substitutes "authorized" for "licensed" for
7 consistency with terminology used throughout this
8 code.

9 (2) Section 2(a), V.T.I.C. Article 21.53A,
10 refers to an approved nonprofit health corporation
11 that is "certified under Section 5.01(a), Medical
12 Practice Act," and holds a certificate of authority
13 "issued by the commissioner under Article 21.52F."
14 The revised law omits the reference to certification
15 under Section 5.01(a), Medical Practice Act (Article
16 4495b, Vernon's Texas Civil Statutes), which was
17 codified in 1999 in Chapter 162, Occupations Code, as
18 unnecessary because V.T.I.C. Article 21.52F, revised
19 as Chapter 844 of this code, requires a nonprofit
20 corporation to be certified under that provision as a
21 condition of holding a certificate of authority. The
22 revised law also omits as unnecessary the reference to
23 the commissioner issuing the certificate of authority
24 because Chapter 844 requires the commissioner to issue
25 the certificate of authority.

26 Revised Law

27 Sec. 1360.003. EXCEPTION. This chapter does not apply to:

- 28 (1) a plan that provides coverage:
- 29 (A) only for a specified disease or another
30 limited benefit;
 - 31 (B) only for accidental death or dismemberment;
 - 32 (C) for wages or payments in lieu of wages for a
33 period during which an employee is absent from work because of
34 sickness or injury;

1 (D) as a supplement to a liability insurance
2 policy;

3 (E) for credit insurance;

4 (F) only for vision care; or

5 (G) only for indemnity for hospital confinement;

6 (2) a Medicare supplemental policy as defined by
7 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

8 (3) a workers' compensation insurance policy;

9 (4) a small employer health benefit plan written under
10 Chapter 1501;

11 (5) medical payment insurance coverage provided under
12 a motor vehicle insurance policy; or

13 (6) a long-term care insurance policy, including a
14 nursing home fixed indemnity policy, unless the commissioner
15 determines that the policy provides benefit coverage so
16 comprehensive that the policy is a health benefit plan as described
17 by Section 1360.002. (V.T.I.C. Art. 21.53A, Sec. 2(b).)

18 Source Law

19 (b) This article does not apply to:

20 (1) a plan that provides coverage:

21 (A) only for a specified disease or
22 other limited benefit;

23 (B) only for accidental death or
24 dismemberment;

25 (C) for wages or payments in lieu of
26 wages for a period during which an employee is absent
27 from work because of sickness or injury;

28 (D) as a supplement to liability
29 insurance;

30 (E) for credit insurance;

31 (F) only for vision care; or

32 (G) only for indemnity for hospital
33 confinement;

34 (2) a Medicare supplemental policy as
35 defined by Section 1882(g)(1), Social Security Act (42
36 U.S.C. Section 1395ss);

37 (3) workers' compensation insurance
38 coverage;

39 (4) a small employer plan written under
40 Chapter 26 of this code;

41 (5) medical payment insurance issued as
42 part of a motor vehicle insurance policy; or

43 (6) a long-term care policy, including a
44 nursing home fixed indemnity policy, unless the
45 commissioner determines that the policy provides
46 benefit coverage so comprehensive that the policy is a
47 health benefit plan as described by Subsection (a) of
48 this section.

1 Revised Law

2 Sec. 1360.004. COVERAGE REQUIRED. (a) A health benefit
3 plan that provides coverage for medically necessary diagnostic or
4 surgical treatment of conditions affecting skeletal joints must
5 provide comparable coverage for diagnostic or surgical treatment of
6 conditions affecting the temporomandibular joint if the treatment
7 is medically necessary as a result of:

- 8 (1) an accident;
9 (2) a trauma;
10 (3) a congenital defect;
11 (4) a developmental defect; or
12 (5) a pathology.

13 (b) Coverage required under this section may be subject to
14 any provision in the health benefit plan that is generally
15 applicable to surgical treatment, including a requirement for
16 precertification of coverage. (V.T.I.C. Art. 21.53A, Secs. 3(a)
17 (part), (b), (c).)

18 Source Law

19 Sec. 3. (a) Each health benefit plan . . . that
20 provides benefits for the medically necessary
21 diagnostic or surgical treatment of skeletal joints
22 must provide comparable coverage as provided by this
23 article for the medically necessary diagnostic or
24 surgical treatment of conditions affecting the
25 temporomandibular joint. . . .

26 (b) Each health benefit plan shall provide
27 coverage under this article for diagnosis or surgical
28 treatment medically necessary as a result of:

- 29 (1) an accident;
30 (2) a trauma;
31 (3) a congenital defect;
32 (4) a developmental defect; or
33 (5) a pathology.

34 (c) All other provisions generally applicable
35 to surgical treatment under the health benefit plan
36 may be applied to the benefits required under this
37 article, including any requirements for
38 precertification of benefits.

39 Revised Law

40 Sec. 1360.005. DENTAL SERVICES COVERAGE NOT REQUIRED. (a)
41 This chapter does not require a health benefit plan to provide
42 coverage for dental services if dental services are not otherwise
43 scheduled or provided as part of the coverage provided under the

1 plan.

2 (b) A health benefit plan may not exclude from coverage
3 under the plan an individual who is unable to undergo dental
4 treatment in an office setting or under local anesthesia due to a
5 documented physical, mental, or medical reason as determined by the
6 individual's physician or by the dentist providing the dental care.
7 (V.T.I.C. Art. 21.53A, Sec. 4.)

8 Source Law

9 Sec. 4. (a) This article does not require a
10 health benefit plan to provide dental services if
11 dental services are not otherwise scheduled or
12 provided as a part of the benefits covered under the
13 health benefit plan.

14 (b) A health benefit plan may not exclude from
15 coverage under the plan an individual who is unable to
16 undergo dental treatment in an office setting or under
17 local anesthesia due to a documented physical, mental,
18 or medical reason as determined by the individual's
19 physician or the dentist providing the dental care.

20 Revisor's Note
21 (End of Chapter)

22 Section 1, V.T.I.C. Article 21.53A, defines
23 "health benefit plan." The revised law omits the
24 definition as unnecessary because Section 2 of that
25 article, revised as Sections 1360.002 and 1360.003,
26 specifies the types of health benefit plans to which
27 this chapter applies, and thus the defined term is not
28 helpful to the reader. The omitted law reads:

29 Art. 21.53A
30 Sec. 1. In this article, "health
31 benefit plan" means a plan described by
32 Section 2 of this article.

33 CHAPTER 1361. DETECTION AND PREVENTION OF OSTEOPOROSIS

34 Sec. 1361.001. DEFINITION 964
35 Sec. 1361.002. APPLICABILITY OF CHAPTER 965
36 Sec. 1361.003. COVERAGE REQUIRED 966

37 CHAPTER 1361. DETECTION AND PREVENTION OF OSTEOPOROSIS

38 Revised Law

39 Sec. 1361.001. DEFINITION. In this chapter, "qualified
40 enrollee" means an individual entitled to coverage under a group
41 health benefit plan who is:

1 (1) a postmenopausal woman who is not receiving
2 estrogen replacement therapy;

3 (2) an individual with:

4 (A) vertebral abnormalities;

5 (B) primary hyperparathyroidism; or

6 (C) a history of bone fractures; or

7 (3) an individual who is:

8 (A) receiving long-term glucocorticoid therapy;

9 or

10 (B) being monitored to assess the response to or
11 efficacy of an approved osteoporosis drug therapy. (V.T.I.C.
12 Art. 21.53C, Secs. (b), (c) (part).)

13 Source Law

14 (b) "Qualified individual" means:

15 (1) a postmenopausal woman who is not
16 receiving estrogen replacement therapy;

17 (2) an individual with:

18 (A) vertebral abnormalities;

19 (B) primary hyperparathyroidism; or

20 (C) a history of bone fractures; or

21 (3) an individual who is:

22 (A) receiving long-term glucocorti
23 coid therapy; or

24 (B) being monitored to assess the
25 response to or efficacy of an approved osteoporosis
26 drug therapy.

27 (c) [A group health insurance policy must
28 provide coverage for a qualified individual] covered
29 by the policy

30 Revised Law

31 Sec. 1361.002. APPLICABILITY OF CHAPTER. This chapter
32 applies only to a group health benefit plan delivered, issued for
33 delivery, or renewed in this state that provides coverage for
34 medical or surgical expenses incurred as a result of accident or
35 sickness, including:

36 (1) a group insurance policy;

37 (2) a group contract issued by a group hospital
38 service corporation operating under Chapter 842; and

39 (3) a group contract issued by a health maintenance
40 organization operating under Chapter 843. (V.T.I.C. Art. 21.53C,
41 Sec. (a).)

1 associated with osteoporosis. (V.T.I.C. Art. 21.53C, Sec. (c)
2 (part).)

3 Source Law

4 (c) A group health insurance policy must provide
5 coverage for a qualified individual . . . for
6 medically accepted bone mass measurement for the
7 detection of low bone mass and to determine the
8 person's risk of osteoporosis and fractures associated
9 with osteoporosis.

10 CHAPTER 1362. CERTAIN TESTS FOR DETECTION OF PROSTATE CANCER

11 Sec. 1362.001. APPLICABILITY OF CHAPTER 967
12 Sec. 1362.002. EXCEPTION. 970
13 Sec. 1362.003. COVERAGE REQUIRED 971
14 Sec. 1362.004. NOTICE OF COVERAGE. 972
15 Sec. 1362.005. RULES 972

16 CHAPTER 1362. CERTAIN TESTS FOR DETECTION OF PROSTATE CANCER

17 Revised Law

18 Sec. 1362.001. APPLICABILITY OF CHAPTER. This chapter
19 applies only to a health benefit plan that:

20 (1) provides benefits for medical or surgical expenses
21 incurred as a result of a health condition, accident, or sickness,
22 including:

23 (A) an individual, group, blanket, or franchise
24 insurance policy or insurance agreement, a group hospital service
25 contract, or an individual or group evidence of coverage that is
26 offered by:

27 (i) an insurance company;

28 (ii) a group hospital service corporation
29 operating under Chapter 842;

30 (iii) a fraternal benefit society operating
31 under Chapter 885;

32 (iv) a stipulated premium company operating
33 under Chapter 884; or

34 (v) a health maintenance organization
35 operating under Chapter 843; and

36 (B) to the extent permitted by the Employee

1 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et
2 seq.), a health benefit plan that is offered by:

3 (i) a multiple employer welfare arrangement
4 as defined by Section 3 of that Act; or

5 (ii) another analogous benefit
6 arrangement;

7 (2) is offered by:

8 (A) an approved nonprofit health corporation
9 that holds a certificate of authority under Chapter 844; or

10 (B) an entity not authorized under this code or
11 another insurance law of this state that contracts directly for
12 health care services on a risk-sharing basis, including a
13 capitation basis; or

14 (3) provides health and accident coverage through a
15 risk pool created under Chapter 172, Local Government Code,
16 notwithstanding Section 172.014, Local Government Code, or any
17 other law. (V.T.I.C. Art. 21.53F, Sec. 2(a), as added Acts 75th
18 Leg., R.S., Ch. 1287.)

19 Source Law

20 Sec. 2. (a) This article applies to a health
21 benefit plan that:

22 (1) provides benefits for medical or
23 surgical expenses incurred as a result of a health
24 condition, accident, or sickness, including:

25 (A) an individual, group, blanket, or
26 franchise insurance policy or insurance agreement, a
27 group hospital service contract, or an individual or
28 group evidence of coverage that is offered by:

29 (i) an insurance company;
30 (ii) a group hospital service
31 corporation operating under Chapter 20 of this code;

32 (iii) a fraternal benefit
33 society operating under Chapter 10 of this code;

34 (iv) a stipulated premium
35 insurance company operating under Chapter 22 of this
36 code; or

37 (v) a health maintenance
38 organization operating under the Texas Health
39 Maintenance Organization Act (Chapter 20A, Vernon's
40 Texas Insurance Code); and

41 (B) to the extent permitted by the
42 Employee Retirement Income Security Act of 1974 (29
43 U.S.C. Section 1001 et seq.), a health benefit plan
44 that is offered by:

45 (i) a multiple employer welfare
46 arrangement as defined by Section 3, Employee
47 Retirement Income Security Act of 1974 (29 U.S.C.
48 Section 1002); or

1 (ii) another analogous benefit
2 arrangement;

3 (2) is offered by an approved nonprofit
4 health corporation that is certified under Section
5 5.01(a), Medical Practice Act (Article 4495b, Vernon's
6 Texas Civil Statutes), and that holds a certificate of
7 authority issued by the commissioner under Article
8 21.52F of this code;

9 (3) is offered by any other entity not
10 licensed under this code or another insurance law of
11 this state that contracts directly for health care
12 services on a risk-sharing basis, including an entity
13 that contracts for health care services on a
14 capitation basis; or

15 (4) notwithstanding Section 172.014,
16 Local Government Code, or any other law, provides
17 health and accident coverage through a risk pool
18 created under Chapter 172, Local Government Code.

19 Revisor's Note

20 (1) Section 2(a), V.T.I.C. Article 21.53F, as
21 added by Chapter 1287, Acts of the 75th Legislature,
22 Regular Session, 1997, refers to an approved nonprofit
23 health corporation that is "certified under Section
24 5.01(a), Medical Practice Act," and holds a
25 certificate of authority "issued by the commissioner
26 under Article 21.52F." The revised law omits the
27 reference to certification under Section 5.01(a),
28 Medical Practice Act (Article 4495b, Vernon's Texas
29 Civil Statutes), which was codified in 1999 in Chapter
30 162, Occupations Code, as unnecessary because V.T.I.C.
31 Article 21.52F, revised as Chapter 844 of this code,
32 requires a nonprofit corporation to be certified under
33 that provision as a condition of holding a certificate
34 of authority. The revised law also omits as
35 unnecessary the reference to the commissioner issuing
36 the certificate of authority because Chapter 844
37 requires the commissioner to issue the certificate of
38 authority.

39 (2) Section 2(a), V.T.I.C. Article 21.53F, as
40 added by Chapter 1287, Acts of the 75th Legislature,
41 Regular Session, 1997, refers to a health benefit plan
42 offered by an entity that is not "licensed" under the
43 Insurance Code or another insurance law of this state.

1 The revised law substitutes "authorized" for
2 "licensed" for consistency with terminology used
3 throughout this code.

4 Revised Law

5 Sec. 1362.002. EXCEPTION. This chapter does not apply to:

6 (1) a health benefit plan that provides coverage:

7 (A) only for a specified disease or for another
8 limited benefit;

9 (B) only for accidental death or dismemberment;

10 (C) for wages or payments in lieu of wages for a
11 period during which an employee is absent from work because of
12 sickness or injury;

13 (D) as a supplement to a liability insurance
14 policy; or

15 (E) only for indemnity for hospital confinement;

16 (2) a small employer health benefit plan written under
17 Chapter 1501;

18 (3) a Medicare supplemental policy as defined by
19 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

20 (4) a workers' compensation insurance policy;

21 (5) medical payment insurance coverage provided under
22 a motor vehicle insurance policy; or

23 (6) a long-term care insurance policy, including a
24 nursing home fixed indemnity policy, unless the commissioner
25 determines that the policy provides benefit coverage so
26 comprehensive that the policy is a health benefit plan as described
27 by Section 1362.001. (V.T.I.C. Art. 21.53F, Sec. 2(b), as added
28 Acts 75th Leg., R.S., Ch. 1287.)

29 Source Law

30 (b) This article does not apply to:

31 (1) a plan that provides coverage:

32 (A) only for a specified disease or
33 other limited benefit;

34 (B) only for accidental death or
35 dismemberment;

36 (C) for wages or payments in lieu of
37 wages for a period during which an employee is absent
38 from work because of sickness or injury;

1 (D) as a supplement to liability
2 insurance; or
3 (E) only for indemnity for hospital
4 confinement;
5 (2) a plan written under Chapter 26 of this
6 code;
7 (3) a Medicare supplemental policy as
8 defined by Section 1882(g)(1), Social Security Act (42
9 U.S.C. Section 1395ss);
10 (4) workers' compensation insurance
11 coverage;
12 (5) medical payment insurance issued as
13 part of a motor vehicle insurance policy; or
14 (6) a long-term care policy, including a
15 nursing home fixed indemnity policy, unless the
16 commissioner determines that the policy provides
17 benefit coverage so comprehensive that the policy is a
18 health benefit plan as described by Subsection (a) of
19 this section.

20 Revisor's Note

21 Section 2(b)(2), V.T.I.C. Article 21.53F, as
22 added by Chapter 1287, Acts of the 75th Legislature,
23 Regular Session, 1997, refers to "a plan written under
24 Chapter 26 of this code." The revised law refers to a
25 "small employer health benefit plan written under
26 Chapter 1501." When Article 21.53F was enacted,
27 Chapter 26 addressed only benefit plans offered by
28 small employers. Provisions addressing benefit plans
29 offered by large employers were later added to Chapter
30 26 through the enactment of Chapter 955, Acts of the
31 75th Legislature, Regular Session, 1997.
32 Consequently, the reference to "a small employer
33 health benefit plan" correctly reflects legislative
34 intent.

35 Revised Law

36 Sec. 1362.003. COVERAGE REQUIRED. (a) A health benefit
37 plan that provides coverage for diagnostic medical procedures must
38 provide to each male enrolled in the plan coverage for expenses for
39 an annual medically recognized diagnostic examination for the
40 detection of prostate cancer.

41 (b) Coverage required under this section includes at a
42 minimum:

43 (1) a physical examination for the detection of

1 prostate cancer; and

2 (2) a prostate-specific antigen test used for the
3 detection of prostate cancer for each male who:

4 (A) is at least 50 years of age and is
5 asymptomatic; or

6 (B) is at least 40 years of age and has a family
7 history of prostate cancer or another prostate cancer risk factor.

8 (V.T.I.C. Art. 21.53F, Sec. 3, as added Acts 75th Leg., R.S., Ch.
9 1287.)

10 Source Law

11 Sec. 3. (a) A health benefit plan that
12 provides benefits for diagnostic medical procedures
13 must provide coverage for each male enrolled in the
14 plan for expenses incurred in conducting an annual
15 medically recognized diagnostic examination for the
16 detection of prostate cancer.

17 (b) The minimum benefits provided under
18 Subsection (a) of this section must include:

19 (1) a physical examination for the
20 detection of prostate cancer; and

21 (2) a prostate-specific antigen test used
22 for the detection of prostate cancer for each male
23 enrolled in the plan who is:

24 (A) at least 50 years of age and
25 asymptomatic; or

26 (B) at least 40 years of age with a
27 family history of prostate cancer or another prostate
28 cancer risk factor.

29 Revised Law

30 Sec. 1362.004. NOTICE OF COVERAGE. (a) A health benefit
31 plan issuer shall provide to each individual enrolled in the plan
32 written notice of the coverage required under this chapter.

33 (b) The notice must be provided in accordance with rules
34 adopted by the commissioner. (V.T.I.C. Art. 21.53F, Sec. 4, as
35 added Acts 75th Leg., R.S., Ch. 1287.)

36 Source Law

37 Sec. 4. Each health benefit plan shall provide
38 written notice to each person enrolled in the plan
39 regarding the coverage required by this article. The
40 notice must be provided in accordance with rules
41 adopted by the commissioner.

42 Revised Law

43 Sec. 1362.005. RULES. The commissioner shall adopt rules
44 necessary to administer this chapter. (V.T.I.C. Art. 21.53F, Sec.

1 5, as added Acts 75th Leg., R.S., Ch. 1287.)

2 Source Law

3 Sec. 5. The commissioner shall adopt rules as
4 necessary to administer this article.

5 Revisor's Note
6 (End of Chapter)

7 Section 1, V.T.I.C. Article 21.53F, as added by
8 Chapter 1287, Acts of the 75th Legislature, Regular
9 Session, 1997, defines "health benefit plan." The
10 revised law omits the definition as unnecessary
11 because Section 2 of that article, revised as Sections
12 1362.001 and 1362.002, specifies the types of health
13 benefit plans to which this chapter applies, and thus
14 the defined term is not helpful to the reader. The
15 omitted law reads:

16 Art. 21.53F
17 Sec. 1. In this article, "health
18 benefit plan" means a plan described by
19 Section 2 of this article.

20 CHAPTER 1363. CERTAIN TESTS FOR DETECTION OF COLORECTAL CANCER

21	Sec. 1363.001.	APPLICABILITY OF CHAPTER	973
22	Sec. 1363.002.	EXCEPTION.	975
23	Sec. 1363.003.	MINIMUM COVERAGE REQUIRED	977
24	Sec. 1363.004.	NOTICE OF COVERAGE.	977
25	Sec. 1363.005.	RULES	978

26 CHAPTER 1363. CERTAIN TESTS FOR DETECTION OF COLORECTAL CANCER

27 Revised Law

28 Sec. 1363.001. APPLICABILITY OF CHAPTER. This chapter
29 applies only to a health benefit plan that:

30 (1) provides benefits for medical or surgical expenses
31 incurred as a result of a health condition, accident, or sickness,
32 including:

33 (A) an individual, group, blanket, or franchise
34 insurance policy or insurance agreement, a group hospital service
35 contract, or an individual or group evidence of coverage that is
36 offered by:

- 1 (i) an insurance company;
- 2 (ii) a group hospital service corporation
3 operating under Chapter 842;
- 4 (iii) a fraternal benefit society operating
5 under Chapter 885;
- 6 (iv) a Lloyd's plan operating under Chapter
7 941;
- 8 (v) a stipulated premium company operating
9 under Chapter 884; or
- 10 (vi) a health maintenance organization
11 operating under Chapter 843; and

12 (B) to the extent permitted by the Employee
13 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et
14 seq.), a health benefit plan that is offered by:

- 15 (i) a multiple employer welfare arrangement
16 as defined by Section 3 of that Act; or
- 17 (ii) another analogous benefit
18 arrangement;

19 (2) is offered by an approved nonprofit health
20 corporation operating under Chapter 844; or

21 (3) provides health and accident coverage through a
22 risk pool created under Chapter 172, Local Government Code,
23 notwithstanding Section 172.014, Local Government Code, or any
24 other law. (V.T.I.C. Art. 21.53S, Sec. 2(a).)

25 Source Law

26 Sec. 2. (a) This article applies to a health
27 benefit plan that:

28 (1) provides benefits for medical or
29 surgical expenses incurred as a result of a health
30 condition, accident, or sickness, including:

31 (A) an individual, group, blanket, or
32 franchise insurance policy or insurance agreement, a
33 group hospital service contract, or an individual or
34 group evidence of coverage that is offered by:

- 35 (i) an insurance company;
- 36 (ii) a group hospital service
37 corporation operating under Chapter 20 of this code;
- 38 (iii) a fraternal benefit
39 society operating under Chapter 10 of this code;
- 40 (iv) a Lloyd's plan operating
41 under Chapter 18 of this code;
- 42 (v) a stipulated premium

1 insurance company operating under Chapter 22 of this
2 code; or

3 (vi) a health maintenance
4 organization operating under the Texas Health
5 Maintenance Organization Act (Chapter 20A, Vernon's
6 Texas Insurance Code); and

7 (B) to the extent permitted by the
8 Employee Retirement Income Security Act of 1974 (29
9 U.S.C. Section 1001 et seq.), a health benefit plan
10 that is offered by:

11 (i) a multiple employer welfare
12 arrangement as defined by Section 3, Employee
13 Retirement Income Security Act of 1974 (29 U.S.C.
14 Section 1002); or

15 (ii) another analogous benefit
16 arrangement;

17 (2) is offered by an approved nonprofit
18 health corporation that is certified under Section
19 162.001, Occupations Code, and that holds a
20 certificate of authority issued by the commissioner
21 under Article 21.52F of this code; or

22 (3) notwithstanding Section 172.014,
23 Local Government Code, or any other law, provides
24 health and accident coverage through a risk pool
25 created under Chapter 172, Local Government Code.

26 Revisor's Note

27 Section 2(a), V.T.I.C. Article 21.53S, refers to
28 an approved nonprofit health corporation that is
29 "certified under Section 162.001, Occupations Code,"
30 and holds a certificate of authority "issued by the
31 commissioner under Article 21.52F." The revised law
32 omits the reference in Article 21.53S to certification
33 under Section 162.001, Occupations Code, as
34 unnecessary because V.T.I.C. Article 21.52F, revised
35 as Chapter 844 of this code, requires an approved
36 nonprofit health corporation to be certified under
37 Section 162.001, Occupations Code, as a condition of
38 holding a certificate of authority. The revised law
39 also omits as unnecessary the reference to the
40 commissioner's issuing the certificate of authority
41 because Chapter 844 requires the commissioner to issue
42 the certificate of authority.

43 Revised Law

44 Sec. 1363.002. EXCEPTION. This chapter does not apply to:

45 (1) a plan that provides coverage:

46 (A) only for a specified disease or other limited

1 benefit;

2 (B) only for accidental death or dismemberment;

3 (C) for wages or payments in lieu of wages for a
4 period during which an employee is absent from work because of
5 sickness or injury;

6 (D) as a supplement to a liability insurance
7 policy; or

8 (E) only for indemnity for hospital confinement;

9 (2) a small employer health benefit plan written under
10 Chapter 1501;

11 (3) a Medicare supplemental policy as defined by
12 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),
13 as amended;

14 (4) a workers' compensation insurance policy;

15 (5) medical payment insurance coverage provided under
16 a motor vehicle insurance policy; or

17 (6) a long-term care policy, including a nursing home
18 fixed indemnity policy, unless the commissioner determines that the
19 policy provides benefit coverage so comprehensive that the policy
20 is a health benefit plan as described by Section 1363.001.
21 (V.T.I.C. Art. 21.53S, Sec. 2(b).)

22 Source Law

23 (b) This article does not apply to:

24 (1) a plan that provides coverage:

25 (A) only for a specified disease or
26 other limited benefit;

27 (B) only for accidental death or
28 dismemberment;

29 (C) for wages or payments in lieu of
30 wages for a period during which an employee is absent
31 from work because of sickness or injury;

32 (D) as a supplement to liability
33 insurance; or

34 (E) only for indemnity for hospital
35 confinement;

36 (2) a small employer plan written under
37 Chapter 26 of this code;

38 (3) a Medicare supplemental policy as
39 defined by Section 1882(g)(1), Social Security Act (42
40 U.S.C. Section 1395ss), as amended;

41 (4) workers' compensation insurance
42 coverage;

43 (5) medical payment insurance issued as
44 part of a motor vehicle insurance policy; or

45 (6) a long-term care policy, including a

1 nursing home fixed indemnity policy, unless the
2 commissioner determines that the policy provides
3 benefit coverage so comprehensive that the policy is a
4 health benefit plan as described by Subsection (a) of
5 this section.

6 Revised Law

7 Sec. 1363.003. MINIMUM COVERAGE REQUIRED. (a) A health
8 benefit plan that provides coverage for screening medical
9 procedures must provide to each individual enrolled in the plan who
10 is 50 years of age or older and at normal risk for developing colon
11 cancer coverage for expenses incurred in conducting a medically
12 recognized screening examination for the detection of colorectal
13 cancer.

14 (b) The minimum coverage required under this section must
15 include:

16 (1) a fecal occult blood test performed annually and a
17 flexible sigmoidoscopy performed every five years; or

18 (2) a colonoscopy performed every 10 years. (V.T.I.C.
19 Art. 21.53S, Sec. 3.)

20 Source Law

21 Sec. 3. (a) A health benefit plan that
22 provides benefits for screening medical procedures
23 must provide coverage for each person enrolled in the
24 plan who is 50 years of age or older and at normal risk
25 for developing colon cancer for expenses incurred in
26 conducting a medically recognized screening
27 examination for the detection of colorectal cancer.

28 (b) The minimum benefits provided under
29 Subsection (a) of this section must:

30 (1) include:

31 (A) a fecal occult blood test
32 performed annually; and

33 (B) a flexible sigmoidoscopy
34 performed every five years; or

35 (2) include a colonoscopy performed every
36 10 years.

37 Revised Law

38 Sec. 1363.004. NOTICE OF COVERAGE. (a) A health benefit
39 plan issuer shall provide to each individual enrolled in the plan
40 written notice of the coverage required under this chapter.

41 (b) The notice must be provided in accordance with rules
42 adopted by the commissioner. (V.T.I.C. Art. 21.53S, Sec. 4.)

43 Source Law

44 Sec. 4. Each health benefit plan shall provide

1 written notice to each person enrolled in the plan
2 regarding the coverage required by this article. The
3 notice must be provided in accordance with rules
4 adopted by the commissioner.

5 Revised Law

6 Sec. 1363.005. RULES. The commissioner shall adopt rules
7 as necessary to administer this chapter. (V.T.I.C. Art. 21.53S,
8 Sec. 5.)

9 Source Law

10 Sec. 5. The commissioner shall adopt rules as
11 necessary to administer this article.

12 Revisor's Note
13 (End of Chapter)

14 Section 1, V.T.I.C. Article 21.53S, defines
15 "health benefit plan." The revised law omits the
16 definition as unnecessary because Section 2 of that
17 article, revised as Sections 1363.001 and 1363.002,
18 specifies the types of health benefit plans to which
19 this chapter applies, and thus the defined term is not
20 helpful to the reader. The omitted law reads:

21 Art. 21.53S
22 Sec. 1. In this article, "health
23 benefit plan" means a plan described by
24 Section 2 of this article.

25 CHAPTER 1364. COVERAGE PROVISIONS RELATING TO HIV, AIDS,
26 OR HIV-RELATED ILLNESSES

27 SUBCHAPTER A. EXCLUSION FROM OR DENIAL OF COVERAGE PROHIBITED

28 Sec. 1364.001. APPLICABILITY OF SUBCHAPTER 979
29 Sec. 1364.002. EXCEPTION. 980
30 Sec. 1364.003. PROHIBITION 982
31 Sec. 1364.004. RULES 982

32 [Sections 1364.005-1364.050 reserved for expansion]

33 SUBCHAPTER B. CANCELLATION OF GROUP COVERAGE PROHIBITED

34 Sec. 1364.051. DEFINITIONS 983
35 Sec. 1364.052. APPLICABILITY OF SUBCHAPTER 983
36 Sec. 1364.053. PROHIBITION 983

37 [Sections 1364.054-1364.100 reserved for expansion]

1 SUBCHAPTER C. CERTAIN COVERAGES PROVIDED BY LOCAL GOVERNMENTS

2 Sec. 1364.101. PROHIBITION ON EXCLUSION OR

3 LIMITATION OF COVERAGES 984

4 CHAPTER 1364. COVERAGE PROVISIONS RELATING TO HIV, AIDS,
5 OR HIV-RELATED ILLNESSES

6 SUBCHAPTER A. EXCLUSION FROM OR DENIAL OF COVERAGE PROHIBITED

7 Revised Law

8 Sec. 1364.001. APPLICABILITY OF SUBCHAPTER. This
9 subchapter applies only to a group health benefit plan that is
10 delivered, issued for delivery, or renewed and that is:

11 (1) a group accident and health insurance policy;

12 (2) a group contract issued by a group hospital
13 service corporation operating under Chapter 842; or

14 (3) a group evidence of coverage issued by a health
15 maintenance organization operating under Chapter 843. (V.T.I.C.
16 Art. 3.51-6, Sec. 3C (part), as added Acts 71st Leg., R.S., Ch.
17 1041, Sec. 14.)

18 Source Law

19 Sec. 3C. [No] group policy of accident, health,
20 or accident and health insurance including group
21 contracts issued by any hospital and medical service
22 plan corporation subject to Chapter 20 of this code and
23 health maintenance organization subject to Chapter 20A
24 of this code . . . delivered or issued for delivery or
25 renewed

26 Revisor's Note

27 (1) Section 3C, V.T.I.C. Article 3.51-6, as
28 added by Section 14, Chapter 1041, Acts of the 71st
29 Legislature, Regular Session, 1989, refers to a "group
30 policy of accident, health, or accident and health
31 insurance." The revised law substitutes "group
32 accident and health insurance policy" for "group
33 policy of accident, health, or accident and health
34 insurance" to provide for consistent use of
35 terminology throughout this code.

36 (2) Section 3C, V.T.I.C. Article 3.51-6, as
37 added by Section 14, Chapter 1041, Acts of the 71st

1 Legislature, Regular Session, 1989, refers to a
2 "hospital and medical service plan corporation"
3 subject to V.T.I.C. Chapter 20, revised as Chapter 842
4 of this code. The term most frequently used to
5 describe such a corporation is "group hospital service
6 corporation." Consequently, the revised law
7 substitutes "group hospital service corporation" for
8 "hospital and medical service plan corporation" to
9 provide for consistent use of terminology throughout
10 this code.

11 (3) Section 3C, V.T.I.C. Article 3.51-6, as
12 added by Section 14, Chapter 1041, Acts of the 71st
13 Legislature, Regular Session, 1989, refers to group
14 "contracts" issued by a health maintenance
15 organization subject to V.T.I.C. Chapter 20A, revised
16 in relevant part as Chapter 843 of this code. The term
17 most frequently used to describe the type of coverage
18 document issued by a health maintenance organization
19 is "evidence of coverage." Consequently, the revised
20 law substitutes "evidence of coverage" for "contracts"
21 to provide for consistent use of terminology
22 throughout this code.

23 Revised Law

24 Sec. 1364.002. EXCEPTION. This subchapter does not apply
25 to:

26 (1) a credit accident and health insurance policy
27 subject to Chapter 1153;

28 (2) any group specifically provided for or authorized
29 by law in existence and covered under a policy filed with the State
30 Board of Insurance before April 1, 1975;

31 (3) accident or health coverage that is incidental to
32 any form of a group automobile, casualty, property, workers'
33 compensation, or employers' liability policy approved by the
34 department; or

1 (4) any policy or contract of insurance with a state
2 agency, department, or board providing health services:

3 (A) to eligible individuals under Chapter 32,
4 Human Resources Code; or

5 (B) under a state plan adopted in accordance with
6 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section
7 1397aa et seq., as amended. (V.T.I.C. Art. 3.51-6, Sec. 4.)

8 Source Law

9 Sec. 4. The provisions of this article shall not
10 be applicable to:

11 (1) credit accident and health insurance
12 policies subject to Article 3.53 of the Insurance
13 Code, as amended;

14 (2) any group specifically provided for or
15 authorized by law in existence and covered under a
16 policy filed with the State Board of Insurance prior to
17 April 1, 1975;

18 (3) accident and health coverages that are
19 incidental to any form of group automobile, casualty,
20 property, or workmen's compensation--employers'
21 liability policies promulgated or approved by the
22 State Board of Insurance;

23 (4) any policy or contract of insurance
24 with a state agency, department, or board providing
25 health services to all eligible persons under Chapter
26 32, Human Resources Code, or in accordance with 42
27 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C.
28 Section 1397aa et seq., as amended, under a state plan.

29 Revisor's Note

30 (1) Section 4(1), V.T.I.C. Article 3.51-6,
31 refers to "Article 3.53 of the Insurance Code, as
32 amended." The revised law omits "as amended" because
33 Section 311.027, Government Code (Code Construction
34 Act), applicable to the revised law, provides that
35 unless expressly provided otherwise, a reference to
36 any portion of a statute applies to all reenactments,
37 revisions, or amendments of the statute.

38 (2) Section 4(3), V.T.I.C. Article 3.51-6,
39 refers to the State Board of Insurance. Chapter 685,
40 Acts of the 73rd Legislature, Regular Session, 1993,
41 abolished the board and transferred its functions to
42 the commissioner of insurance and the Texas Department
43 of Insurance. The reference to the board has been

1 changed appropriately.

2 Revised Law

3 Sec. 1364.003. PROHIBITION. A group health benefit plan
4 may not exclude or deny coverage for:

- 5 (1) human immunodeficiency virus (HIV);
6 (2) acquired immune deficiency syndrome (AIDS); or
7 (3) an HIV-related illness. (V.T.I.C. Art. 3.51-6,
8 Sec. 3C (part), as added Acts 71st Leg., R.S., Ch. 1041, Sec. 14.)

9 Source Law

10 Sec. 3C. No group policy [of accident, health,
11 or accident and health insurance including group
12 contracts issued by any hospital and medical service
13 plan corporation subject to Chapter 20 of this code and
14 health maintenance organization subject to Chapter 20A
15 of this code] shall be [delivered or issued for
16 delivery or renewed] that excludes or denies coverage
17 for HIV, AIDS, or HIV-related illnesses.

18 Revised Law

19 Sec. 1364.004. RULES. The commissioner may adopt rules
20 necessary to administer this subchapter. A rule adopted under this
21 section is subject to notice and hearing as provided by Section
22 1201.007 for a rule adopted under Chapter 1201. (V.T.I.C.
23 Art. 3.51-6, Sec. 5.)

24 Source Law

25 Sec. 5. The State Board of Insurance is
26 authorized to issue such rules and regulations as may
27 be necessary to carry out the various provisions of
28 this article. Rules and regulations promulgated
29 pursuant to this article shall be subject to notice and
30 hearing pursuant to Section 10, Chapter 397, Acts of
31 the 54th Legislature, Regular Session, 1955 (Article
32 3.70-10, Vernon's Texas Insurance Code).

33 Revisor's Note

34 Section 5, V.T.I.C. Article 3.51-6, refers to
35 "rules and regulations." The revised law omits the
36 reference to "regulations" because under Section
37 311.005(5), Government Code (Code Construction Act), a
38 rule is defined to include a regulation. That
39 definition applies to the revised law.

40 [Sections 1364.005-1364.050 reserved for expansion]

1 SUBCHAPTER B. CANCELLATION OF GROUP COVERAGE PROHIBITED

2 Revised Law

3 Sec. 1364.051. DEFINITIONS. In this subchapter, "AIDS"
4 and "HIV" have the meanings assigned by Section 81.101, Health and
5 Safety Code. (V.T.I.C. Art. 3.51-6D, Subsec. (a) (part).)

6 Source Law

7 Art. 3.51-6D. (a) [Except as provided by
8 Subsection (b) of this article, an insurer that
9 delivers or issues for delivery a policy or contract of
10 group health insurance in this state, including a
11 group hospital service corporation under Chapter 20 of
12 this code, may not cancel during the term of the policy
13 or contract the coverage of a person covered by that
14 policy or contract because that person has been
15 diagnosed as having or has been or is being treated for
16 HIV or AIDS] as defined by Section 81.101, Health and
17 Safety Code.

18 Revised Law

19 Sec. 1364.052. APPLICABILITY OF SUBCHAPTER. This
20 subchapter applies to an insurer that delivers or issues for
21 delivery a group health insurance policy or contract in this state,
22 including a group hospital service corporation operating under
23 Chapter 842. (V.T.I.C. Art. 3.51-6D, Subsec. (a) (part).)

24 Source Law

25 Art. 3.51-6D. (a) [Except as provided by
26 Subsection (b) of this article, an insurer] that
27 delivers or issues for delivery a policy or contract of
28 group health insurance in this state, including a
29 group hospital service corporation under Chapter 20 of
30 this code, [may not cancel during the term of the
31 policy or contract the coverage of a person covered by
32 that policy or contract because that person has been
33 diagnosed as having or has been or is being treated for
34 HIV or AIDS as defined by Section 81.101, Health and
35 Safety Code.]

36 Revised Law

37 Sec. 1364.053. PROHIBITION. (a) Except as provided by
38 Subsection (b), an insurer may not cancel during the term of a group
39 health insurance policy or contract an individual's coverage
40 provided by the policy or contract because the individual:

41 (1) has been diagnosed as having AIDS or HIV;

42 (2) has been treated for AIDS or HIV; or

43 (3) is being treated for AIDS or HIV.

44 (b) The insurer may cancel the coverage provided by the

1 policy or contract for fraud or misrepresentation in the obtaining
2 of coverage by failure to disclose a diagnosis of AIDS or an
3 HIV-related condition. (V.T.I.C. Art. 3.51-6D, Subsecs. (a)
4 (part), (b).)

5 Source Law

6 Art. 3.51-6D. (a) Except as provided by
7 Subsection (b) of this article, an insurer . . . may
8 not cancel during the term of the policy or contract
9 the coverage of a person covered by that policy or
10 contract because that person has been diagnosed as
11 having or has been or is being treated for HIV or AIDS
12
13 (b) An insurer may cancel coverage under a
14 policy or contract covered by Subsection (a) of this
15 article if there was fraud or misrepresentation in
16 obtaining the coverage by not disclosing a diagnosis
17 of AIDS and HIV-related conditions.

18 [Sections 1364.054-1364.100 reserved for expansion]

19 SUBCHAPTER C. CERTAIN COVERAGES PROVIDED BY LOCAL GOVERNMENTS

20 Revised Law

21 Sec. 1364.101. PROHIBITION ON EXCLUSION OR LIMITATION OF
22 COVERAGES. A political subdivision that provides group health
23 insurance coverage, health maintenance organization coverage, or
24 self-insured health care coverage to the political subdivision's
25 officers or employees may not contract for or provide coverage that
26 excludes or limits coverage or services for:

27 (1) acquired immune deficiency syndrome, as defined by
28 the Centers for Disease Control and Prevention of the United States
29 Public Health Service; or

30 (2) human immunodeficiency virus infection.
31 (V.T.I.C. Art. 3.51-5A, Subsec. (a) (part).)

32 Source Law

33 Art. 3.51-5A. (a) A municipality, county,
34 school district, district created under Article III,
35 Section 52, or Article XVI, Section 59, of the Texas
36 Constitution, or other political subdivision of the
37 state that provides group health insurance coverage,
38 health maintenance organization coverage, or
39 self-insured health care coverage to its officers or
40 employees or to both its officers and employees may not
41 contract for or provide coverage that:

42 (1) excludes or limits coverage or
43 services for acquired immune deficiency syndrome, as
44 defined by the Centers for Disease Control of the
45 United States Public Health Service, or human
46 immunodeficiency virus infection; or

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Revisor's Note

(1) Subsection (a), V.T.I.C. Article 3.51-5A, refers to "[a] municipality, county, school district, district created under Article III, Section 52, or Article XVI, Section 59, of the Texas Constitution, or other political subdivision of the state." The revised law substitutes the term "political subdivision" for the quoted language because each type of entity specified is included in the meaning of "political subdivision."

(2) Section (a)(1), V.T.I.C. Article 3.51-5A, refers to the "Centers for Disease Control of the United States Public Health Service." The revised law substitutes the current name for these centers, "Centers for Disease Control and Prevention of the United States Public Health Service."

CHAPTER 1365. LOSS OR IMPAIRMENT OF SPEECH OR HEARING

Sec. 1365.001.	APPLICABILITY OF CHAPTER	985
Sec. 1365.002.	APPLICABILITY OF GENERAL PROVISIONS	
	OF OTHER LAW	986
Sec. 1365.003.	OFFER OF COVERAGE REQUIRED	987
Sec. 1365.004.	RIGHT TO REJECT COVERAGE OR SELECT	
	ALTERNATIVE COVERAGE	987

CHAPTER 1365. LOSS OR IMPAIRMENT OF SPEECH OR HEARING

Revised Law

Sec. 1365.001. APPLICABILITY OF CHAPTER. This chapter applies only to a group health benefit plan that provides hospital and medical coverage on an expense-incurred, service, or prepaid basis, including a group policy, contract, or plan that is offered in this state by:

- (1) an insurer;
- (2) a group hospital service corporation operating under Chapter 842; or

1 (3) a health maintenance organization operating under
2 Chapter 843. (V.T.I.C. Art. 3.70-2, Sec. (G) (part).)

3 Source Law

4 (G) Insurers, nonprofit hospital and medical
5 service plan corporations subject to Chapter 20 of
6 this code, and health maintenance organizations
7 transacting health insurance or providing other health
8 coverage in this state . . . under group policies,
9 contracts, and plans providing hospital and medical
10 coverage on an expense incurred, service or prepaid
11 basis

12 Revisor's Note

13 Section (G), V.T.I.C. Article 3.70-2, refers to
14 "nonprofit hospital and medical service plan
15 corporations" subject to V.T.I.C. Chapter 20, revised
16 as Chapter 842 of this code. The term most frequently
17 used to refer to such a corporation is "group hospital
18 service corporation." Consequently, the revised law
19 substitutes "group hospital service corporation" for
20 "nonprofit hospital and medical service plan
21 corporations" to provide for consistent use of
22 terminology throughout this code.

23 Revised Law

24 Sec. 1365.002. APPLICABILITY OF GENERAL PROVISIONS OF OTHER
25 LAW. The provisions of Chapter 1201, including provisions
26 relating to the applicability, purpose, and enforcement of that
27 chapter, construction of policies under that chapter, rulemaking
28 under that chapter, and definitions of terms applicable in that
29 chapter, apply to this chapter. (New.)

30 Revisor's Note

31 Chapter 397, Acts of the 54th Legislature,
32 Regular Session, 1955, published as V.T.I.C. Articles
33 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4,
34 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and
35 3.70-11, contains general provisions applicable to
36 Section (G), V.T.I.C. Article 3.70-2, revised as this
37 chapter. The majority of these articles are revised in

1 this code as Chapter 1201. Section 1365.002 is added
2 to indicate the applicability of those general
3 provisions to this chapter. For the convenience of the
4 reader, the revised law includes general descriptions
5 of some of the applicable provisions of Chapter 1201.

6 Revised Law

7 Sec. 1365.003. OFFER OF COVERAGE REQUIRED. (a) A group
8 health benefit plan issuer shall offer and make available under the
9 plan coverage for the necessary care and treatment of loss or
10 impairment of speech or hearing.

11 (b) Coverage required under this section:

12 (1) may not be less favorable than coverage for
13 physical illness generally under the plan; and

14 (2) must be subject to the same durational limits,
15 dollar limits, deductibles, and coinsurance factors as coverage for
16 physical illness generally under the plan. (V.T.I.C. Art. 3.70-2,
17 Sec. (G) (part).)

18 Source Law

19 (G) [Insurers, nonprofit hospital and medical
20 service plan corporations subject to Chapter 20 of
21 this code, and health maintenance organizations
22 transacting health insurance or providing other health
23 coverage in this state] shall offer and make
24 available, [under group policies, contracts, and plans
25 providing hospital and medical coverage on an expense
26 incurred, service or prepaid basis,] benefits for the
27 necessary care and treatment of loss or impairment of
28 speech or hearing that are not less favorable than for
29 physical illness generally, subject to the same
30 durational limits, dollar limits, deductibles, and
31 coinsurance factors. . . .

32 Revised Law

33 Sec. 1365.004. RIGHT TO REJECT COVERAGE OR SELECT
34 ALTERNATIVE COVERAGE. An offer of coverage required under Section
35 1365.003 is subject to the right of the group contract holder to
36 reject the coverage or to select an alternative level of coverage
37 that is offered by or negotiated with the group health benefit plan
38 issuer. (V.T.I.C. Art. 3.70-2, Sec. (G) (part).)

39 Source Law

40 (G) . . . Such offer of benefits shall be

1 subject to the right of the group policy or contract
2 holder to reject the coverage or to select any
3 alternative level of benefits if such right is offered
4 by or negotiated with such insurer, service plan
5 corporation, or health maintenance organization.

6 CHAPTER 1366. BENEFITS RELATED TO FERTILITY AND CHILDBIRTH

7 SUBCHAPTER A. COVERAGE FOR IN VITRO FERTILIZATION PROCEDURES

8 Sec. 1366.001. APPLICABILITY OF SUBCHAPTER 988
9 Sec. 1366.002. EXCEPTION. 989
10 Sec. 1366.003. OFFER OF COVERAGE REQUIRED 991
11 Sec. 1366.004. REJECTION OF OFFER. 992
12 Sec. 1366.005. CONDITIONS APPLICABLE TO COVERAGE 992
13 Sec. 1366.006. CERTAIN ISSUERS OF HEALTH BENEFIT PLANS
14 NOT REQUIRED TO OFFER COVERAGE 994
15 Sec. 1366.007. RULES 995

16 [Sections 1366.008-1366.050 reserved for expansion]

17 SUBCHAPTER B. MINIMUM INPATIENT STAY FOLLOWING

18 BIRTH OF CHILD AND POSTDELIVERY CARE

19 Sec. 1366.051. SHORT TITLE. 995
20 Sec. 1366.052. DEFINITIONS 995
21 Sec. 1366.053. APPLICABILITY OF SUBCHAPTER 996
22 Sec. 1366.054. EXCEPTION. 999
23 Sec. 1366.055. COVERAGE FOR INPATIENT CARE REQUIRED 1000
24 Sec. 1366.056. COVERAGE FOR POSTDELIVERY CARE REQUIRED . . . 1001
25 Sec. 1366.057. PROHIBITED CONDUCT 1002
26 Sec. 1366.058. NOTICE OF COVERAGE. 1004
27 Sec. 1366.059. RULES 1004

28 CHAPTER 1366. BENEFITS RELATED TO FERTILITY AND CHILDBIRTH

29 SUBCHAPTER A. COVERAGE FOR IN VITRO FERTILIZATION PROCEDURES

30 Revised Law

31 Sec. 1366.001. APPLICABILITY OF SUBCHAPTER. This
32 subchapter applies only to a group health benefit plan that
33 provides benefits for hospital, medical, or surgical expenses
34 incurred as a result of accident or sickness, including a group
35 health insurance policy, health care service contract or plan, or
36 other provision of group health benefits, coverage, or services in

1 this state that is issued, entered into, or provided by:

2 (1) an insurer;

3 (2) a group hospital service corporation operating
4 under Chapter 842;

5 (3) a health maintenance organization operating under
6 Chapter 843; or

7 (4) an employer, multiple employer, union,
8 association, trustee, or other self-funded or self-insured welfare
9 or benefit plan, program, or arrangement. (V.T.I.C. Art. 3.51-6,
10 Sec. 3A(a) (part).)

11 Source Law

12 Sec. 3A. (a) All insurers, nonprofit hospital
13 and medical service plan corporations subject to
14 Chapter 20 of this code, health maintenance
15 organizations subject to the Texas Health Maintenance
16 Organization Act (Chapter 20A, Vernon's Texas
17 Insurance Code), and all employer, multiple-employer,
18 union, association, trustee, or other self-funded or
19 self-insured welfare or benefit plans, programs, or
20 arrangements that either issue group health insurance
21 policies, enter into health care service contracts or
22 plans, or provide for group health benefits, coverage,
23 or services in this state for hospital, medical, or
24 surgical expenses incurred as a result of accident or
25 sickness [shall offer and make available . . .
26 coverage]

27 Revisor's Note

28 Section 3A(a), V.T.I.C. Article 3.51-6, refers to
29 "nonprofit hospital and medical service plan
30 corporations" subject to V.T.I.C. Chapter 20, revised
31 as Chapter 842 of this code. The term most frequently
32 used to refer to such a corporation is "group hospital
33 service corporation." Consequently, the revised law
34 substitutes "group hospital service corporation" for
35 "nonprofit hospital and medical service plan
36 corporations" to provide for consistent use of
37 terminology throughout this code.

38 Revised Law

39 Sec. 1366.002. EXCEPTION. This subchapter does not apply
40 to:

41 (1) a credit accident and health insurance policy

1 subject to Chapter 1153;

2 (2) any group specifically provided for or authorized
3 by law in existence and covered under a policy filed with the State
4 Board of Insurance before April 1, 1975;

5 (3) accident and health coverages that are incidental
6 to any form of a group automobile, casualty, property, workers'
7 compensation, or employers' liability policy approved by the
8 commissioner; or

9 (4) any policy or contract of insurance with a state
10 agency, department, or board providing health services:

11 (A) to eligible individuals under Chapter 32,
12 Human Resources Code; or

13 (B) under a state plan adopted in accordance with
14 42 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C. Section
15 1397aa et seq., as amended. (V.T.I.C. Art. 3.51-6, Sec. 4.)

16 Source Law

17 Sec. 4. The provisions of this article shall not
18 be applicable to:

19 (1) credit accident and health insurance
20 policies subject to Article 3.53 of the Insurance
21 Code, as amended;

22 (2) any group specifically provided for or
23 authorized by law in existence and covered under a
24 policy filed with the State Board of Insurance prior to
25 April 1, 1975;

26 (3) accident and health coverages that are
27 incidental to any form of group automobile, casualty,
28 property, or workmen's compensation--employers'
29 liability policies promulgated or approved by the
30 State Board of Insurance;

31 (4) any policy or contract of insurance
32 with a state agency, department, or board providing
33 health services to all eligible persons under Chapter
34 32, Human Resources Code, or in accordance with 42
35 U.S.C. Sections 1396-1396g, as amended, or 42 U.S.C.
36 Section 1397aa et seq., as amended, under a state plan.

37 Revisor's Note

38 (1) Section 4(1), V.T.I.C. Article 3.51-6,
39 refers to "Article 3.53 of the Insurance Code, as
40 amended." The revised law omits "as amended" because
41 Section 311.027, Government Code (Code Construction
42 Act), applicable to the revised law, provides that
43 unless expressly provided otherwise, a reference to

1 any portion of a statute applies to all reenactments,
2 revisions, or amendments of the statute.

3 (2) Section 4(3), V.T.I.C. Article 3.51-6,
4 refers to the State Board of Insurance. Chapter 685,
5 Acts of the 73rd Legislature, Regular Session, 1993,
6 abolished the board and transferred its functions to
7 the commissioner of insurance and the Texas Department
8 of Insurance. The reference to the board has been
9 changed appropriately.

10 Revised Law

11 Sec. 1366.003. OFFER OF COVERAGE REQUIRED. (a) Subject
12 to this subchapter, an issuer of a group health benefit plan that
13 provides pregnancy-related benefits for individuals covered under
14 the plan shall offer and make available to each holder or sponsor of
15 the plan coverage for services and benefits on an expense incurred,
16 service, or prepaid basis for outpatient expenses that arise from
17 in vitro fertilization procedures.

18 (b) Benefits for in vitro fertilization procedures required
19 under this section must be provided to the same extent as benefits
20 provided for other pregnancy-related procedures under the plan.
21 (V.T.I.C. Art. 3.51-6, Secs. 3A(a) (part), (b), (d).)

22 Source Law

23 (a) [All insurers, nonprofit hospital and
24 medical service plan corporations subject to Chapter
25 20 of this code, health maintenance organizations
26 subject to the Texas Health Maintenance Organization
27 Act (Chapter 20A, Vernon's Texas Insurance Code), and
28 all employer, multiple-employer, union, association,
29 trustee, or other self-funded or self-insured welfare
30 or benefit plans, programs, or arrangements that
31 either issue group health insurance policies, enter
32 into health care service contracts or plans, or
33 provide for group health benefits, coverage, or
34 services in this state for hospital, medical, or
35 surgical expenses incurred as a result of accident or
36 sickness] shall offer and make available to each group
37 policyholder, contract holder, employer,
38 multiple-employer, union, association, or trustee
39 under a group policy, contract, plan, program, or
40 arrangement that provides hospital, surgical, and
41 medical benefits, coverage for services and benefits
42 on an expense incurred, service, or prepaid basis for
43 out-patient expenses that may arise from in vitro
44 fertilization procedures, if the group insurance
45 policy, contract, plan, program, or arrangement

1 otherwise provides pregnancy-related benefits for the
2 insureds, enrollees, subscribers, employees, members,
3 or other persons covered under the policy contract,
4 plan, program, or arrangement.

5 (b) An offer made under Subsection (a) of this
6 section is subject to this section.

7 (d) Benefits for in vitro fertilization
8 procedures must be provided to the same extent as the
9 benefits provided for other pregnancy-related
10 procedures under the policy, contract, plan, program,
11 or arrangement.

12 Revisor's Note

13 Section 3A(a), V.T.I.C. Article 3.51-6, requires
14 an issuer of a group health benefit plan to provide
15 certain coverage to each "group policyholder, contract
16 holder, employer, multiple-employer, union,
17 association, or trustee" under the plan. For drafting
18 convenience, the revised law substitutes "holder or
19 sponsor" for the quoted language because the entities
20 listed are the types of entities that would hold or
21 sponsor a group health benefit plan to which this
22 subchapter applies.

23 Revised Law

24 Sec. 1366.004. REJECTION OF OFFER. A rejection of an offer
25 under Section 1366.003 to provide coverage for in vitro
26 fertilization procedures must be in writing. (V.T.I.C.
27 Art. 3.51-6, Sec. 3A(c).)

28 Source Law

29 (c) A rejection of an offer to provide the
30 coverage for services or benefits provided by
31 Subsection (a) of this section must be in writing.

32 Revised Law

33 Sec. 1366.005. CONDITIONS APPLICABLE TO COVERAGE. The
34 coverage offered under Section 1366.003 is required only if:

35 (1) the patient for the in vitro fertilization
36 procedure is an individual covered under the group health benefit
37 plan;

38 (2) the fertilization or attempted fertilization of
39 the patient's oocytes is made only with the sperm of the patient's
40 spouse;

1 (3) the patient and the patient's spouse have a history
2 of infertility of at least five continuous years' duration or the
3 infertility is associated with:

4 (A) endometriosis;

5 (B) exposure in utero to diethylstilbestrol
6 (DES);

7 (C) blockage of or surgical removal of one or
8 both fallopian tubes; or

9 (D) oligospermia;

10 (4) the patient has been unable to attain a successful
11 pregnancy through any less costly applicable infertility
12 treatments for which coverage is available under the group health
13 benefit plan; and

14 (5) the in vitro fertilization procedures are
15 performed at a medical facility that conforms to the minimal
16 standards for programs of in vitro fertilization adopted by the
17 American Society for Reproductive Medicine. (V.T.I.C.
18 Art. 3.51-6, Sec. 3A(e).)

19 Source Law

20 (e) The offer to make the coverage available is
21 required only under the following conditions:

22 (1) the patient for the in vitro
23 fertilization procedure is an insured, enrollee,
24 subscriber, member, or otherwise covered employee or
25 person under the policy, contract, plan, program, or
26 arrangement;

27 (2) the fertilization or attempt at
28 fertilization of the patient's oocytes is made only
29 with the patient's spouse's sperm;

30 (3) the patient and the patient's spouse
31 have a history of infertility of at least five
32 continuous years' duration or the infertility is
33 associated with one or more of the following
34 conditions:

35 (A) endometriosis;

36 (B) exposure in utero to
37 diethylstilbestrol (DES);

38 (C) blockage of or surgical removal
39 of one or both fallopian tubes; or

40 (D) oligospermia;

41 (4) the patient has been unable to attain a
42 successful pregnancy through any less costly
43 applicable infertility treatments for which coverage
44 is available under the policy, contract, plan,
45 program, or arrangement; and

46 (5) the in vitro fertilization procedures
47 are performed at a medical facility that conforms to
48 the American College of Obstetric and Gynecology

1 guidelines for in vitro fertilization clinics or to
2 the American Fertility Society minimal standards for
3 programs of in vitro fertilization.

4 Revisor's Note

5 (1) Section 3A(e)(5), V.T.I.C. Article 3.51-6,
6 refers to the "American College of Obstetric and
7 Gynecology guidelines for in vitro fertilization
8 clinics." The revised law omits the quoted language
9 because the American College of Obstetricians and
10 Gynecologists (the proper name of "American College of
11 Obstetric and Gynecology") no longer has guidelines
12 for in vitro fertilization clinics.

13 (2) Section 3A(e)(5), V.T.I.C. Article 3.51-6,
14 refers to the "American Fertility Society." The
15 revised law substitutes "American Society for
16 Reproductive Medicine" for "American Fertility
17 Society" because that is now the name of that
18 organization.

19 Revised Law

20 Sec. 1366.006. CERTAIN ISSUERS OF HEALTH BENEFIT PLANS NOT
21 REQUIRED TO OFFER COVERAGE. An insurer, health maintenance
22 organization, or self-insuring employer that is owned by or that is
23 part of an entity, group, or order that is directly affiliated with
24 a bona fide religious denomination that includes as an integral
25 part of its beliefs and practices that in vitro fertilization is
26 contrary to moral principles that the religious denomination
27 considers to be an essential part of its beliefs is not required to
28 offer coverage for in vitro fertilization under Section 1366.003.
29 (V.T.I.C. Art. 3.51-6, Sec. 3A(f).)

30 Source Law

31 (f) An insurer, health maintenance
32 organization, or self-insuring employer that is owned
33 by or that is part of an entity, group, or order that is
34 directly affiliated with a bona fide religious
35 denomination that includes as an integral part of its
36 beliefs and practices that in vitro fertilization is
37 contrary to moral principles that the religious
38 denomination considers to be an essential part of its
39 beliefs is exempt from this section's requirement to
40 offer coverage for in vitro fertilization.

1 Revised Law

2 Sec. 1366.007. RULES. The commissioner may adopt rules
3 necessary to administer this subchapter. A rule adopted under this
4 section is subject to notice and hearing as provided by Section
5 1201.007 for a rule adopted under Chapter 1201. (V.T.I.C.
6 Art. 3.51-6, Sec. 5.)

7 Source Law

8 Sec. 5. The State Board of Insurance is
9 authorized to issue such rules and regulations as may
10 be necessary to carry out the various provisions of
11 this article. Rules and regulations promulgated
12 pursuant to this article shall be subject to notice and
13 hearing pursuant to Section 10, Chapter 397, Acts of
14 the 54th Legislature, Regular Session, 1955 (Article
15 3.70-10, Vernon's Texas Insurance Code).

16 Revisor's Note

17 Section 5, V.T.I.C. Article 3.51-6, refers to
18 "rules and regulations." The revised law omits the
19 reference to "regulations" because under Section
20 311.005(5), Government Code (Code Construction Act), a
21 rule is defined to include a regulation. That
22 definition applies to the revised law.

23 [Sections 1366.008-1366.050 reserved for expansion]

24 SUBCHAPTER B. MINIMUM INPATIENT STAY FOLLOWING
25 BIRTH OF CHILD AND POSTDELIVERY CARE

26 Revised Law

27 Sec. 1366.051. SHORT TITLE. This subchapter may be cited
28 as the Lee Alexandria Hanley Act. (V.T.I.C. Art. 21.53F, Sec. 1, as
29 added Acts 75th Leg., R.S., Ch. 832.)

30 Source Law

31 Art. 21.53F
32 Sec. 1. This article may be cited as the Lee
33 Alexandria Hanley Act.

34 Revised Law

35 Sec. 1366.052. DEFINITIONS. In this subchapter:

36 (1) "Attending physician" means an obstetrician,
37 pediatrician, or other physician who attends a woman who has given
38 birth to a child or who attends a newborn child.

1 (2) "Postdelivery care" means postpartum health care
2 services provided in accordance with accepted maternal and neonatal
3 physical assessments. The term includes parent education,
4 assistance and training in breast-feeding and bottle-feeding, and
5 the performance of any necessary and appropriate clinical tests.
6 (V.T.I.C. Art. 21.53F, Secs. 2(1), 5(c) (part), as added Acts 75th
7 Leg., R.S., Ch. 832.)

8 Source Law

9 Sec. 2. In this article:

10 (1) "Attending physician" means an
11 obstetrician, pediatrician, or other physician who
12 attends a woman who has given birth or who attends the
13 newborn child.

14 [Sec. 5]

15 (c) For purposes of this section, "postdelivery
16 care" means postpartum health care services provided
17 in accordance with accepted maternal and neonatal
18 physical assessments. The term includes parent
19 education, assistance and training in breast-feeding
20 and bottle-feeding, and the performance of any
21 necessary and appropriate clinical tests. . . .

22 Revisor's Note

23 Section 2(3), V.T.I.C. Article 21.53F, as added
24 by Chapter 832, Acts of the 75th Legislature, Regular
25 Session, 1997, defines "health benefit plan." The
26 revised law omits the definition as unnecessary
27 because Section 3 of that article, revised as Sections
28 1366.053 and 1366.054, specifies the types of health
29 benefit plans to which this subchapter applies, and
30 thus the defined term is not helpful to the reader.
31 The omitted law reads:

32 (3) "Health benefit plan" means
33 a plan described by Section 3 of this
34 article.

35 Revised Law

36 Sec. 1366.053. APPLICABILITY OF SUBCHAPTER. This
37 subchapter applies only to a health benefit plan that:

38 (1) provides benefits for medical or surgical expenses
39 incurred as a result of a health condition, accident, or sickness,
40 including:

1 (A) an individual, group, blanket, or franchise
2 insurance policy or insurance agreement, a group hospital service
3 contract, or an individual or group evidence of coverage that is
4 offered by:

5 (i) an insurance company;

6 (ii) a group hospital service corporation
7 operating under Chapter 842;

8 (iii) a fraternal benefit society operating
9 under Chapter 885;

10 (iv) a stipulated premium company operating
11 under Chapter 884; or

12 (v) a health maintenance organization
13 operating under Chapter 843; and

14 (B) to the extent permitted by the Employee
15 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et
16 seq.), a health benefit plan that is offered by:

17 (i) a multiple employer welfare arrangement
18 as defined by Section 3 of that Act;

19 (ii) an entity not authorized under this
20 code or another insurance law of this state that contracts directly
21 for health care services on a risk-sharing basis, including a
22 capitation basis; or

23 (iii) another analogous benefit
24 arrangement; or

25 (2) is offered by an approved nonprofit health
26 corporation that holds a certificate of authority under Chapter
27 844. (V.T.I.C. Art. 21.53F, Sec. 3(a), as added Acts 75th Leg.,
28 R.S., Ch. 832.)

29 Source Law

30 Sec. 3. (a) This article applies to a health
31 benefit plan that:

32 (1) provides benefits for medical or
33 surgical expenses incurred as a result of a health
34 condition, accident, or sickness, including:

35 (A) an individual, group, blanket, or
36 franchise insurance policy or insurance agreement, a
37 group hospital service contract, or an individual or
38 group evidence of coverage that is offered by:

1 (i) an insurance company;
2 (ii) a group hospital service
3 corporation operating under Chapter 20 of this code;
4 (iii) a fraternal benefit
5 society operating under Chapter 10 of this code;
6 (iv) a stipulated premium
7 insurance company operating under Chapter 22 of this
8 code; or
9 (v) a health maintenance
10 organization operating under the Texas Health
11 Maintenance Organization Act (Chapter 20A, Vernon's
12 Texas Insurance Code); or
13 (B) to the extent permitted by the
14 Employee Retirement Income Security Act of 1974 (29
15 U.S.C. Section 1001 et seq.), a health benefit plan
16 that is offered by:
17 (i) a multiple employer welfare
18 arrangement as defined by Section 3, Employee
19 Retirement Income Security Act of 1974 (29 U.S.C.
20 Section 1002);
21 (ii) any other entity not
22 licensed under this code or another insurance law of
23 this state that contracts directly for health care
24 services on a risk-sharing basis, including an entity
25 that contracts for health care services on a
26 capitation basis; or
27 (iii) another analogous benefit
28 arrangement; or
29 (2) is offered by an approved nonprofit
30 health corporation that is certified under Section
31 5.01(a), Medical Practice Act (Article 4495b, Vernon's
32 Texas Civil Statutes), and that holds a certificate of
33 authority issued by the commissioner under Article
34 21.52F of this code.

35 Revisor's Note

36 (1) Section 3(a), V.T.I.C. Article 21.53F, as
37 added by Chapter 832, Acts of the 75th Legislature,
38 Regular Session, 1997, refers to a health benefit plan
39 offered by an entity that is not "licensed" under the
40 Insurance Code or another insurance law of this state.
41 The revised law substitutes "authorized" for
42 "licensed" for consistency with terminology used
43 throughout this code.

44 (2) Section 3(a), V.T.I.C. Article 21.53F, as
45 added by Chapter 832, Acts of the 75th Legislature,
46 Regular Session, 1997, refers to an approved nonprofit
47 health corporation that is "certified under Section
48 5.01(a), Medical Practice Act," and holds a
49 certificate of authority "issued by the commissioner
50 under Article 21.52F." The revised law omits the
51 reference to certification under Section 5.01(a),

1 Medical Practice Act (Article 4495b, Vernon's Texas
2 Civil Statutes), which was codified in 1999 in Chapter
3 162, Occupations Code, as unnecessary because V.T.I.C.
4 Article 21.52F, revised as Chapter 844 of this code,
5 requires a nonprofit corporation to be certified under
6 that provision as a condition of holding a certificate
7 of authority. The revised law also omits as
8 unnecessary the reference to the commissioner issuing
9 the certificate of authority because Chapter 844
10 requires the commissioner to issue the certificate of
11 authority.

12 Revised Law

13 Sec. 1366.054. EXCEPTION. This subchapter does not apply
14 to:

- 15 (1) a plan that provides coverage:
- 16 (A) only for a specified disease or for another
17 limited benefit;
- 18 (B) only for accidental death or dismemberment;
- 19 (C) for wages or payments in lieu of wages for a
20 period during which an employee is absent from work because of
21 sickness or injury;
- 22 (D) as a supplement to a liability insurance
23 policy;
- 24 (E) for credit insurance;
- 25 (F) only for dental or vision care; or
- 26 (G) only for indemnity for hospital confinement;
- 27 (2) a Medicare supplemental policy as defined by
28 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);
- 29 (3) a workers' compensation insurance policy;
- 30 (4) medical payment insurance coverage provided under
31 a motor vehicle insurance policy; or
- 32 (5) a long-term care insurance policy, including a
33 nursing home fixed indemnity policy, unless the commissioner
34 determines that the policy provides benefit coverage so

1 comprehensive that the policy is a health benefit plan as described
2 by Section 1366.053. (V.T.I.C. Art. 21.53F, Sec. 3(b), as added
3 Acts 75th Leg., R.S., Ch. 832.)

4 Source Law

5 (b) This article does not apply to:

6 (1) a plan that provides coverage:

7 (A) only for a specified disease or
8 other limited benefit;

9 (B) only for accidental death or
10 dismemberment;

11 (C) for wages or payments in lieu of
12 wages for a period during which an employee is absent
13 from work because of sickness or injury;

14 (D) as a supplement to liability
15 insurance;

16 (E) for credit insurance;

17 (F) only for dental or vision care;

18 or

19 (G) only for indemnity for hospital
20 confinement;

21 (2) a Medicare supplemental policy as
22 defined by Section 1882(g)(1), Social Security Act (42
23 U.S.C. Section 1395ss);

24 (3) workers' compensation insurance
25 coverage;

26 (4) medical payment insurance issued as
27 part of a motor vehicle insurance policy; or

28 (5) a long-term care policy, including a
29 nursing home fixed indemnity policy, unless the
30 commissioner determines that the policy provides
31 benefit coverage so comprehensive that the policy is a
32 health benefit plan as described by Subsection (a) of
33 this section.

34 Revised Law

35 Sec. 1366.055. COVERAGE FOR INPATIENT CARE REQUIRED. (a)

36 Except as provided by Subsection (b), a health benefit plan that
37 provides maternity benefits, including benefits for childbirth,
38 must provide to a woman who has given birth to a child and the
39 newborn child coverage for inpatient care in a health care facility
40 for not less than:

41 (1) 48 hours after an uncomplicated vaginal delivery;

42 and

43 (2) 96 hours after an uncomplicated delivery by
44 cesarean section.

45 (b) A health benefit plan that provides to a woman who has
46 given birth to a child and the newborn child coverage for in-home
47 postdelivery care is not required to provide the coverage required
48 under Subsection (a) unless:

1 (1) the attending physician determines that inpatient
2 care is medically necessary; or

3 (2) the woman requests inpatient care.

4 (c) For purposes of Subsection (a), the attending physician
5 shall determine whether a delivery is complicated.

6 (d) This section does not require a woman who is eligible
7 for coverage under a health benefit plan to:

8 (1) give birth to a child in a hospital or other health
9 care facility; or

10 (2) remain under inpatient care in a hospital or other
11 health care facility for any fixed term following the birth of a
12 child. (V.T.I.C. Art. 21.53F, Sec. 4, as added Acts 75th Leg.,
13 R.S., Ch. 832.)

14 Source Law

15 Sec. 4. (a) A health benefit plan that
16 provides maternity benefits, including benefits for
17 childbirth, must include coverage for inpatient care
18 for a mother and her newborn child in a health care
19 facility for a minimum of:

20 (1) 48 hours following an uncomplicated
21 vaginal delivery; and

22 (2) 96 hours following an uncomplicated
23 delivery by caesarean section.

24 (b) Notwithstanding Subsection (a) of this
25 section, a health benefit plan that provides coverage
26 for in-home postdelivery care to a mother and her
27 newborn child is not required to provide the minimum
28 hours of coverage of inpatient care required under
29 Subsection (a) of this section unless that inpatient
30 care is determined to be medically necessary by an
31 attending physician or is requested by the mother.

32 (c) For purposes of Subsection (a) of this
33 section, the determination as to whether a delivery is
34 complicated shall be made by the attending physician.

35 (d) This article does not require a mother who
36 is eligible for coverage under a health benefit plan
37 to:

38 (1) give birth in a hospital or other
39 health care facility; or

40 (2) remain under inpatient care in a
41 hospital or other health care facility for any fixed
42 term following the birth of a child.

43 Revised Law

44 Sec. 1366.056. COVERAGE FOR POSTDELIVERY CARE REQUIRED.

45 (a) If a decision is made to discharge a woman who has given birth
46 to a child or the newborn child from inpatient care before the
47 expiration of the minimum hours of coverage required under Section

1 1366.055(a), a health benefit plan must provide to the woman and
2 child coverage for timely postdelivery care.

3 (b) The timeliness of the postdelivery care shall be
4 determined in accordance with recognized medical standards for that
5 care.

6 (c) The postdelivery care may be provided by a physician,
7 registered nurse, or other appropriate licensed health care
8 provider.

9 (d) Subject to Subsection (e), the postdelivery care may be
10 provided at:

- 11 (1) the woman's home;
- 12 (2) a health care provider's office;
- 13 (3) a health care facility; or
- 14 (4) another location determined to be appropriate
15 under rules adopted by the commissioner.

16 (e) The coverage required under this section must give the
17 woman the option to have the care provided in the woman's home.
18 (V.T.I.C. Art. 21.53F, Secs. 5(a), (b), (c) (part), as added Acts
19 75th Leg., R.S., Ch. 832.)

20 Source Law

21 Sec. 5. (a) If a decision is made to discharge
22 a mother or newborn child from inpatient care before
23 the expiration of the minimum hours of coverage of
24 inpatient care required under Section 4(a) of this
25 article, the health benefit plan must provide coverage
26 for timely postdelivery care. That care may be
27 provided to the mother and child by a physician,
28 registered nurse, or other appropriate licensed health
29 care provider and may be provided at:

- 30 (1) the mother's home, a health care
31 provider's office, or a health care facility; or
- 32 (2) another location determined to be
33 appropriate under rules adopted by the commissioner.

34 (b) The coverage required under Subsection (a)
35 of this section must allow the mother the option to
36 have the care provided in the mother's home.

37 (c) . . . The timeliness of the care shall be
38 determined in accordance with recognized medical
39 standards for that care.

40 Revised Law

41 Sec. 1366.057. PROHIBITED CONDUCT. An issuer of a health
42 benefit plan may not:

- 43 (1) modify the terms and conditions of coverage based

1 on a request by an enrollee for less than the minimum coverage
2 required under Section 1366.055(a);

3 (2) offer to a woman who has given birth to a child a
4 financial incentive or other compensation the receipt of which is
5 contingent on the waiver by the woman of the minimum coverage
6 required under Section 1366.055(a);

7 (3) refuse to accept a physician's recommendation for
8 inpatient care made in consultation with the woman who has given
9 birth to a child if the period of inpatient care recommended by the
10 physician does not exceed the minimum periods recommended in
11 guidelines for perinatal care developed by:

12 (A) the American College of Obstetricians and
13 Gynecologists;

14 (B) the American Academy of Pediatrics; or

15 (C) another nationally recognized professional
16 association of obstetricians and gynecologists or of
17 pediatricians;

18 (4) reduce payments or other forms of reimbursement
19 for inpatient care below the usual and customary rate of
20 reimbursement for that care; or

21 (5) penalize a physician for recommending inpatient
22 care for a woman or the woman's newborn child by:

23 (A) refusing to permit the physician to
24 participate as a provider in the health benefit plan;

25 (B) reducing payments made to the physician;

26 (C) requiring the physician to:

27 (i) provide additional documentation; or

28 (ii) undergo additional utilization
29 review; or

30 (D) imposing other analogous sanctions or
31 disincentives. (V.T.I.C. Art. 21.53F, Sec. 6, as added Acts 75th
32 Leg., R.S., Ch. 832.)

33 Source Law

34 Sec. 6. A health benefit plan may not:

1 (1) modify the terms and conditions of
2 coverage based on the determination by a person
3 enrolled in the health benefit plan to request less
4 than the minimum coverage required under Section 4(a)
5 of this article;

6 (2) offer to the mother of a newborn child
7 financial incentives or other compensation the receipt
8 of which is contingent on the waiver by the mother of
9 the minimum hours of coverage of inpatient care
10 required under Section 4(a) of this article;

11 (3) refuse to accept a physician's
12 recommendation for a specified period of inpatient
13 care made in consultation with the mother of the
14 newborn child if the period recommended by the
15 physician does not exceed the minimum periods
16 recommended in guidelines for perinatal care developed
17 by the American College of Obstetricians and
18 Gynecologists, the American Academy of Pediatrics, or
19 another nationally recognized professional
20 association of obstetricians and gynecologists or of
21 pediatricians;

22 (4) reduce payments or other forms of
23 reimbursement for inpatient care below the usual and
24 customary rate of reimbursement for that care; or

25 (5) penalize a physician for recommending
26 inpatient care for a mother or her newborn child by:

27 (A) refusing to allow the physician
28 to participate as a provider within the health benefit
29 plan;

30 (B) reducing payments made to the
31 physician;

32 (C) requiring the physician to
33 provide additional documentation or undergo
34 additional utilization review; or

35 (D) imposing other analogous
36 sanctions or disincentives.

37 Revised Law

38 Sec. 1366.058. NOTICE OF COVERAGE. (a) An issuer of a
39 health benefit plan shall provide to each individual enrolled in
40 the plan written notice of the coverage required under this
41 subchapter.

42 (b) The notice must be provided in accordance with rules
43 adopted by the commissioner. (V.T.I.C. Art. 21.53F, Secs. 2(2), 7,
44 as added Acts 75th Leg., R.S., Ch. 832.)

45 Source Law

46 [Sec. 2. In this article:]

47 (2) "Enrollee" means an individual
48 enrolled in a health benefit plan.

49 Sec. 7. In accordance with rules adopted by the
50 commissioner, each health benefit plan must provide to
51 each enrollee under the plan written notice regarding
52 the coverage required by this article.

53 Revised Law

54 Sec. 1366.059. RULES. The commissioner shall adopt rules

1 necessary to administer this subchapter. (V.T.I.C. Art. 21.53F,
2 Sec. 8, as added Acts 75th Leg., R.S., Ch. 832.)

3 Source Law

4 Sec. 8. The commissioner shall adopt rules as
5 necessary to administer this article.

6 CHAPTER 1367. COVERAGE OF CHILDREN

7 SUBCHAPTER A. NEWBORN CHILDREN

8 Sec. 1367.001. APPLICABILITY OF SUBCHAPTER 1006

9 Sec. 1367.002. APPLICABILITY OF GENERAL PROVISIONS
10 OF OTHER LAW 1007

11 Sec. 1367.003. CERTAIN LIMITATIONS ON COVERAGE FOR
12 NEWBORN CHILDREN PROHIBITED 1007

13 [Sections 1367.004-1367.050 reserved for expansion]

14 SUBCHAPTER B. CHILDHOOD IMMUNIZATIONS

15 Sec. 1367.051. APPLICABILITY OF SUBCHAPTER 1008

16 Sec. 1367.052. EXCEPTION. 1010

17 Sec. 1367.053. COVERAGE REQUIRED 1011

18 Sec. 1367.054. COPAYMENT, DEDUCTIBLE, OR COINSURANCE
19 REQUIREMENT PROHIBITED 1013

20 Sec. 1367.055. RULES 1014

21 [Sections 1367.056-1367.100 reserved for expansion]

22 SUBCHAPTER C. HEARING TEST

23 Sec. 1367.101. APPLICABILITY OF SUBCHAPTER 1014

24 Sec. 1367.102. EXCEPTION. 1016

25 Sec. 1367.103. COVERAGE REQUIRED 1017

26 Sec. 1367.104. COPAYMENT OR COINSURANCE REQUIREMENT
27 PERMITTED; DEDUCTIBLE REQUIREMENT OR

28 DOLLAR LIMIT PROHIBITED; NOTICE REQUIRED. . . 1019

29 Sec. 1367.105. RULES 1019

30 [Sections 1367.106-1367.150 reserved for expansion]

31 SUBCHAPTER D. CHILD CRANIOFACIAL ABNORMALITIES

32 Sec. 1367.151. APPLICABILITY OF SUBCHAPTER 1019

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1 ABNORMALITIES; DEFINITION REQUIRED 1023

2 Sec. 1367.154. RULES 1023

3 CHAPTER 1367. COVERAGE OF CHILDREN

4 SUBCHAPTER A. NEWBORN CHILDREN

5 Revised Law

6 Sec. 1367.001. APPLICABILITY OF SUBCHAPTER. This
7 subchapter applies only to a health benefit plan delivered or
8 issued for delivery in this state that is an individual or group
9 policy of accident and health insurance, including a policy issued
10 by a group hospital service corporation operating under Chapter
11 842. (V.T.I.C. Art. 3.70-2, Sec. (E) (part).)

12 Source Law

13 (E) [No] individual policy or group policy of
14 accident and sickness insurance, including policies
15 issued by companies subject to Chapter 20, Texas
16 Insurance Code, as amended, delivered or issued for
17 delivery to any person in this state

18 Revisor's Note

19 (1) Section (E), V.T.I.C. Article 3.70-2,
20 refers to an individual or group policy of "accident
21 and sickness" insurance. For consistency with modern
22 usage, the revised law substitutes "accident and
23 health" for "accident and sickness" throughout this
24 chapter.

25 (2) Section (E), V.T.I.C. Article 3.70-2,
26 refers to "policies issued by companies" subject to
27 V.T.I.C. Chapter 20, revised as Chapter 842 of this
28 code. The term most frequently used to refer to such a
29 company is "group hospital service corporation."
30 Consequently, the revised law substitutes "group
31 hospital service corporation" for "companies" to
32 provide for consistent use of terminology throughout
33 this code.

34 (3) Section (E), V.T.I.C. Article 3.70-2,
35 refers to Chapter 20, Insurance Code, "as amended."
36 The revised law omits the reference to amendments as

1 unnecessary because Section 311.027, Government Code
2 (Code Construction Act), applicable to the revised
3 law, states that a reference to a statute includes
4 reenactments, revisions, or amendments of that
5 statute.

6 Revised Law

7 Sec. 1367.002. APPLICABILITY OF GENERAL PROVISIONS OF OTHER
8 LAW. The provisions of Chapter 1201, including provisions
9 relating to the applicability, purpose, and enforcement of that
10 chapter, construction of policies under that chapter, rulemaking
11 under that chapter, and definitions of terms applicable in that
12 chapter, apply to this subchapter. (New.)

13 Revisor's Note

14 Section (E), V.T.I.C. Article 3.70-2, was enacted
15 as an amendment to Chapter 397, Acts of the 54th
16 Legislature, Regular Session, 1955, published as
17 V.T.I.C. Articles 3.70-1, 3.70-2, 3.70-3, 3.70-3A,
18 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8,
19 3.70-9, 3.70-10, and 3.70-11. The majority of these
20 articles, which include general provisions applicable
21 to Section (E), V.T.I.C. Article 3.70-2, are revised
22 in this code as Chapter 1201. Section 1367.002 is
23 added to indicate the applicability of those general
24 provisions in this subchapter. For the convenience of
25 the reader, the revised law includes general
26 descriptions of some of the provisions of Chapter
27 1201.

28 Revised Law

29 Sec. 1367.003. CERTAIN LIMITATIONS ON COVERAGE FOR NEWBORN
30 CHILDREN PROHIBITED. A health benefit plan that provides
31 maternity benefits or accident and health coverage for additional
32 newborn children may not be issued in this state if the plan
33 excludes or limits:

- 34 (1) initial coverage of a newborn child for a period of

1 time; or

2 (2) coverage for congenital defects of a newborn
3 child. (V.T.I.C. Art. 3.70-2, Sec. (E) (part).)

4 Source Law

5 (E) No [individual policy or group policy of
6 accident and sickness insurance, including policies
7 issued by companies subject to Chapter 20, Texas
8 Insurance Code,] . . . which provides for accident and
9 sickness coverage of additional newborn children or
10 maternity benefits, may be issued in this state if it
11 contains any provisions excluding or limiting initial
12 coverage of a newborn infant for a period of time, or
13 limitations or exclusions for congenital defects of a
14 newborn child.

15 Revisor's Note

16 Section (E), V.T.I.C. Article 3.70-2, refers to a
17 "newborn infant." For consistency throughout this
18 subchapter, the revised law substitutes "newborn
19 child" for "newborn infant."

20 [Sections 1367.004-1367.050 reserved for expansion]

21 SUBCHAPTER B. CHILDHOOD IMMUNIZATIONS

22 Revised Law

23 Sec. 1367.051. APPLICABILITY OF SUBCHAPTER. This
24 subchapter applies only to a health benefit plan that:

25 (1) provides benefits for medical or surgical expenses
26 incurred as a result of a health condition, accident, or sickness,
27 including an individual, group, blanket, or franchise insurance
28 policy or insurance agreement, a group hospital service contract,
29 or an individual or group evidence of coverage that is offered by:

30 (A) an insurance company;

31 (B) a group hospital service corporation
32 operating under Chapter 842;

33 (C) a fraternal benefit society operating under
34 Chapter 885;

35 (D) a stipulated premium company operating under
36 Chapter 884;

37 (E) a health maintenance organization operating
38 under Chapter 843; or

1 (F) a multiple employer welfare arrangement
2 subject to regulation under Chapter 846;

3 (2) is offered by an approved nonprofit health
4 corporation that holds a certificate of authority under Chapter
5 844; or

6 (3) provides health and accident coverage through a
7 risk pool created under Chapter 172, Local Government Code,
8 notwithstanding Section 172.014, Local Government Code, or any
9 other law. (V.T.I.C. Art. 21.53F, Secs. 2(a), (c), as added Acts
10 75th Leg., R.S., Ch. 683.)

11 Source Law

12 Sec. 2. (a) This article applies only to a
13 health benefit plan that:

14 (1) provides benefits for medical or
15 surgical expenses incurred as a result of a health
16 condition, accident, or sickness, including an
17 individual, group, blanket, or franchise insurance
18 policy or insurance agreement, a group hospital
19 service contract, or an individual or group evidence
20 of coverage that is offered by:

21 (A) an insurance company;

22 (B) a group hospital service
23 corporation operating under Chapter 20 of this code;

24 (C) a fraternal benefit society
25 operating under Chapter 10 of this code;

26 (D) a stipulated premium insurance
27 company operating under Chapter 22 of this code;

28 (E) a health maintenance
29 organization operating under the Texas Health
30 Maintenance Organization Act (Chapter 20A, Vernon's
31 Texas Insurance Code); or

32 (F) a multiple employer welfare
33 arrangement subject to regulation under Subchapter I,
34 Chapter 3 of this code; or

35 (2) is offered by an approved nonprofit
36 health corporation that is certified under Section
37 5.01(a), Medical Practice Act (Article 4495b, Vernon's
38 Texas Civil Statutes), and that holds a certificate of
39 authority issued by the commissioner under Article
40 21.52F of this code.

41 (c) Notwithstanding Section 172.014, Local
42 Government Code, or any other law, this article
43 applies to health and accident coverage provided by a
44 risk pool created under Chapter 172, Local Government
45 Code.

46 Revisor's Note

47 Section 2(a)(2), V.T.I.C. Article 21.53F, as
48 added by Chapter 683, Acts of the 75th Legislature,
49 Regular Session, 1997, refers to an approved nonprofit
50 health corporation that is "certified under Section

1 5.01(a), Medical Practice Act," and holds a
2 certificate of authority "issued by the commissioner
3 under Article 21.52F." The revised law omits the
4 reference to certification under Section 5.01(a),
5 Medical Practice Act (Article 4495b, Vernon's Texas
6 Civil Statutes), which was codified in 1999 in Chapter
7 162, Occupations Code, as unnecessary because V.T.I.C.
8 Article 21.52F, revised as Chapter 844 of this code,
9 requires a nonprofit corporation to be certified under
10 that provision as a condition of holding a certificate
11 of authority. The revised law also omits as
12 unnecessary the reference to the commissioner issuing
13 the certificate of authority because Chapter 844
14 requires the commissioner to issue the certificate of
15 authority.

16 Revised Law

17 Sec. 1367.052. EXCEPTION. This subchapter does not apply
18 to:

- 19 (1) a plan that provides coverage:
- 20 (A) only for a specified disease or for another
21 limited benefit;
 - 22 (B) only for accidental death or dismemberment;
 - 23 (C) for wages or payments in lieu of wages for a
24 period during which an employee is absent from work because of
25 sickness or injury;
 - 26 (D) as a supplement to a liability insurance
27 policy;
 - 28 (E) for credit insurance;
 - 29 (F) only for dental or vision care; or
 - 30 (G) only for indemnity for hospital confinement;
- 31 (2) a small employer health benefit plan written under
32 Chapter 1501;
- 33 (3) a Medicare supplemental policy as defined by
34 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

- 1 (4) a workers' compensation insurance policy;
- 2 (5) medical payment insurance coverage provided under
3 a motor vehicle insurance policy; or
- 4 (6) a long-term care insurance policy, including a
5 nursing home fixed indemnity policy, unless the commissioner
6 determines that the policy provides benefit coverage so
7 comprehensive that the policy is a health benefit plan as described
8 by Section 1367.051. (V.T.I.C. Art. 21.53F, Sec. 2(b), as added
9 Acts 75th Leg., R.S., Ch. 683.)

10 Source Law

- 11 (b) This article does not apply to:
- 12 (1) a plan that provides coverage:
- 13 (A) only for a specified disease or
14 other limited benefit;
- 15 (B) only for accidental death or
16 dismemberment;
- 17 (C) for wages or payments in lieu of
18 wages for a period during which an employee is absent
19 from work because of sickness or injury;
- 20 (D) as a supplement to liability
21 insurance;
- 22 (E) for credit insurance;
- 23 (F) only for dental or vision care;
- 24 or
- 25 (G) only for indemnity for hospital
26 confinement;
- 27 (2) a small employer health benefit plan
28 written under Chapter 26 of this code;
- 29 (3) a Medicare supplemental policy as
30 defined by Section 1882(g)(1), Social Security Act (42
31 U.S.C. Section 1395ss);
- 32 (4) workers' compensation insurance
33 coverage;
- 34 (5) medical payment insurance issued as
35 part of a motor vehicle insurance policy; or
- 36 (6) a long-term care policy, including a
37 nursing home fixed indemnity policy, unless the
38 commissioner determines that the policy provides
39 benefit coverage so comprehensive that the policy is a
40 health benefit plan as described by Subsection (a) of
41 this section.

42 Revised Law

43 Sec. 1367.053. COVERAGE REQUIRED. (a) A health benefit
44 plan that provides coverage for a family member of an insured or
45 enrollee shall provide for each covered child from birth through
46 the date of the child's sixth birthday coverage for:

- 47 (1) immunization against:
- 48 (A) diphtheria;
- 49 (B) haemophilus influenzae type b;

- 1 (C) hepatitis B;
- 2 (D) measles;
- 3 (E) mumps;
- 4 (F) pertussis;
- 5 (G) polio;
- 6 (H) rubella;
- 7 (I) tetanus; and
- 8 (J) varicella; and

9 (2) any other immunization that is required for the
10 child by law.

11 (b) For purposes of Subsection (a), a covered child is a
12 child who, as a result of the child's relationship to an insured or
13 enrollee in a health benefit plan, would be entitled to coverage
14 under an accident and health insurance policy under Section
15 1201.061, 1201.062, 1201.063, or 1201.064.

16 (c) In addition to the immunizations required under
17 Subsection (a), a health maintenance organization that issues a
18 health benefit plan shall provide under the plan coverage for
19 immunization against rotovirus. (V.T.I.C. Art. 20A.09F;
20 Art. 21.53F, Secs. 3, 5, as added Acts 75th Leg., R.S., Ch. 683.)

21 Source Law

22 Art. 20A.09F. In addition to an immunization
23 required under Section 3(a), Article 21.53F, Insurance
24 Code, each health maintenance organization shall
25 include in each health care plan provided by the
26 organization coverage for immunization against
27 rotovirus and any other immunization required for a
28 child by statute or rule.

29 [Art. 21.53F]

30 Sec. 3. A health benefit plan that provides
31 benefits for a family member of the insured shall
32 provide coverage for each covered child described by
33 Section 5 of this article, from birth through the date
34 the child is six years of age, for:

- 35 (1) immunization against:
 - 36 (A) diphtheria;
 - 37 (B) haemophilus influenzae type b;
 - 38 (C) hepatitis B;
 - 39 (D) measles;
 - 40 (E) mumps;
 - 41 (F) pertussis;
 - 42 (G) polio;
 - 43 (H) rubella;
 - 44 (I) tetanus; and
 - 45 (J) varicella; and

1 (2) any other immunization that is
2 required by law for the child.

3 Sec. 5. A child is entitled to benefits under
4 this article if the child, as a result of the child's
5 relationship to an enrollee in the health benefit
6 plan, would be entitled to benefits under an accident
7 and sickness insurance policy under Subsection (K),
8 (L), or (M), Section 2, Chapter 397, Acts of the 54th
9 Legislature, 1955 (Article 3.70-2, Vernon's Texas
10 Insurance Code).

11 Revisor's Note

12 (1) V.T.I.C. Article 20A.09F requires a health
13 maintenance organization to provide coverage for any
14 immunization required for a child by "statute or
15 rule." The revised law substitutes "law" for "statute
16 or rule" because in context "law" is synonymous with
17 "statute or rule" and "law" is the more commonly used
18 term.

19 (2) Section 3, V.T.I.C. Article 21.53F, as added
20 by Chapter 683, Acts of the 75th Legislature, Regular
21 Session, 1997, refers to coverage for a family member
22 of the "insured." "Insured" is a term used in
23 conjunction with traditional insurance. This
24 subchapter also applies to health benefit plans
25 offered by entities such as health maintenance
26 organizations that are not insurers. In relation to
27 those plans, "enrollee" is a more accurate term than
28 "insured," and the revised law consequently adds a
29 reference to "enrollee."

30 Revised Law

31 Sec. 1367.054. COPAYMENT, DEDUCTIBLE, OR COINSURANCE
32 REQUIREMENT PROHIBITED. (a) Coverage required under Section
33 1367.053(a) may not be made subject to a deductible, copayment, or
34 coinsurance requirement.

35 (b) This section does not prohibit the application of a
36 deductible, copayment, or coinsurance requirement to another
37 service provided at the same time the immunization is administered.
38 (V.T.I.C. Art. 21.53F, Sec. 6(a), as added Acts 75th Leg., R.S.,

1 Ch. 683.)

2 Source Law

3 Sec. 6. (a) Benefits required under Section 3
4 of this article may not be made subject to a
5 deductible, copayment, or coinsurance requirement.
6 This subsection does not prohibit the application of a
7 deductible, copayment, or coinsurance requirement to
8 another service provided at the same time as the
9 immunization.

10 Revised Law

11 Sec. 1367.055. RULES. The commissioner may adopt
12 reasonable rules necessary to implement this subchapter. (V.T.I.C.
13 Art. 21.53F, Sec. 7, as added Acts 75th Leg., R.S., Ch. 683.)

14 Source Law

15 Sec. 7. The commissioner may adopt rules as
16 necessary to implement this article.

17 [Sections 1367.056-1367.100 reserved for expansion]

18 SUBCHAPTER C. HEARING TEST

19 Revised Law

20 Sec. 1367.101. APPLICABILITY OF SUBCHAPTER. (a) This
21 subchapter applies only to a health benefit plan that:

22 (1) provides benefits for medical or surgical expenses
23 incurred as a result of a health condition, accident, or sickness,
24 including an individual, group, blanket, or franchise insurance
25 policy or insurance agreement, a group hospital service contract,
26 or an individual or group evidence of coverage that is offered by:

- 27 (A) an insurance company;
- 28 (B) a group hospital service corporation
29 operating under Chapter 842;
- 30 (C) a fraternal benefit society operating under
31 Chapter 885;
- 32 (D) a stipulated premium company operating under
33 Chapter 884;
- 34 (E) a health maintenance organization operating
35 under Chapter 843; or
- 36 (F) a multiple employer welfare arrangement
37 subject to regulation under Chapter 846;

1 (2) is offered by an approved nonprofit health
2 corporation that holds a certificate of authority under Chapter
3 844; or

4 (3) provides health and accident coverage through a
5 risk pool created under Chapter 172, Local Government Code,
6 notwithstanding Section 172.014, Local Government Code, or any
7 other law.

8 (b) This subchapter applies to a health benefit plan
9 described by Subsection (a) that provides coverage to a resident of
10 this state, regardless of whether the plan issuer is located in or
11 outside this state. (V.T.I.C. Art. 21.53F, Secs. 2(a), (c), 4(c)
12 (part), as added Acts 75th Leg., R.S., Ch. 683.)

13 Source Law

14 Sec. 2. (a) This article applies only to a
15 health benefit plan that:

16 (1) provides benefits for medical or
17 surgical expenses incurred as a result of a health
18 condition, accident, or sickness, including an
19 individual, group, blanket, or franchise insurance
20 policy or insurance agreement, a group hospital
21 service contract, or an individual or group evidence
22 of coverage that is offered by:

- 23 (A) an insurance company;
24 (B) a group hospital service
25 corporation operating under Chapter 20 of this code;
26 (C) a fraternal benefit society
27 operating under Chapter 10 of this code;
28 (D) a stipulated premium insurance
29 company operating under Chapter 22 of this code;
30 (E) a health maintenance
31 organization operating under the Texas Health
32 Maintenance Organization Act (Chapter 20A, Vernon's
33 Texas Insurance Code); or
34 (F) a multiple employer welfare
35 arrangement subject to regulation under Subchapter I,
36 Chapter 3 of this code; or

37 (2) is offered by an approved nonprofit
38 health corporation that is certified under Section
39 5.01(a), Medical Practice Act (Article 4495b, Vernon's
40 Texas Civil Statutes), and that holds a certificate of
41 authority issued by the commissioner under Article
42 21.52F of this code.

43 (c) Notwithstanding Section 172.014, Local
44 Government Code, or any other law, this article
45 applies to health and accident coverage provided by a
46 risk pool created under Chapter 172, Local Government
47 Code.

48 [Sec. 4]

49 (c) This section applies to any health benefit
50 plan that provides coverage or benefits to a resident
51 of this state, without regard to whether the issuer of
52 the health benefit plan is located within or outside

1 this state. . . .

2 Revisor's Note

3 Section 2(a), V.T.I.C. Article 21.53F, as added
4 by Chapter 683, Acts of the 75th Legislature, Regular
5 Session, 1997, refers to an approved nonprofit health
6 corporation that is "certified under Section 5.01(a),
7 Medical Practice Act," and holds a certificate of
8 authority "issued by the commissioner under Article
9 21.52F." The revised law omits the reference to
10 certification under Section 5.01(a), Medical Practice
11 Act, and the reference to the commissioner issuing the
12 certificate of authority for the reasons stated in the
13 revisor's note to Section 1367.051.

14 Revised Law

15 Sec. 1367.102. EXCEPTION. This subchapter does not apply
16 to:

17 (1) a plan that provides coverage:

18 (A) only for a specified disease or for another
19 limited benefit;

20 (B) only for accidental death or dismemberment;

21 (C) for wages or payments in lieu of wages for a
22 period during which an employee is absent from work because of
23 sickness or injury;

24 (D) as a supplement to a liability insurance
25 policy;

26 (E) for credit insurance;

27 (F) only for dental or vision care; or

28 (G) only for indemnity for hospital confinement;

29 (2) a small employer health benefit plan written under
30 Chapter 1501;

31 (3) a Medicare supplemental policy as defined by
32 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

33 (4) a workers' compensation insurance policy;

34 (5) medical payment insurance coverage provided under

1 a motor vehicle insurance policy; or

2 (6) a long-term care insurance policy, including a
3 nursing home fixed indemnity policy, unless the commissioner
4 determines that the policy provides benefit coverage so
5 comprehensive that the policy is a health benefit plan as described
6 by Section 1367.101. (V.T.I.C. Art. 21.53F, Sec. 2(b), as added
7 Acts 75th Leg., R.S., Ch. 683.)

8 Source Law

9 (b) This article does not apply to:
10 (1) a plan that provides coverage:
11 (A) only for a specified disease or
12 other limited benefit;
13 (B) only for accidental death or
14 dismemberment;
15 (C) for wages or payments in lieu of
16 wages for a period during which an employee is absent
17 from work because of sickness or injury;
18 (D) as a supplement to liability
19 insurance;
20 (E) for credit insurance;
21 (F) only for dental or vision care;
22 or
23 (G) only for indemnity for hospital
24 confinement;
25 (2) a small employer health benefit plan
26 written under Chapter 26 of this code;
27 (3) a Medicare supplemental policy as
28 defined by Section 1882(g)(1), Social Security Act (42
29 U.S.C. Section 1395ss);
30 (4) workers' compensation insurance
31 coverage;
32 (5) medical payment insurance issued as
33 part of a motor vehicle insurance policy; or
34 (6) a long-term care policy, including a
35 nursing home fixed indemnity policy, unless the
36 commissioner determines that the policy provides
37 benefit coverage so comprehensive that the policy is a
38 health benefit plan as described by Subsection (a) of
39 this section.

40 Revised Law

41 Sec. 1367.103. COVERAGE REQUIRED. (a) A health benefit
42 plan that provides coverage for a family member of an insured or
43 enrollee shall provide to each covered child coverage for:

44 (1) a screening test for hearing loss from birth
45 through the date the child is 30 days of age, as provided by Chapter
46 47, Health and Safety Code; and

47 (2) necessary diagnostic follow-up care related to the
48 screening test from birth through the date the child is 24 months of
49 age.

1 (b) For purposes of Subsection (a), a covered child is a
2 child who, as a result of the child's relationship to an insured or
3 enrollee in a health benefit plan, would be entitled to coverage
4 under an accident and health insurance policy under Section
5 1201.061, 1201.062, 1201.063, or 1201.064.

6 (c) This section does not require a health benefit plan to
7 provide the coverage described by this section to a child of an
8 individual residing in this state if the individual is:

9 (1) employed outside this state; and

10 (2) covered under a health benefit plan maintained for
11 the individual by the individual's employer as an employment
12 benefit. (V.T.I.C. Art. 21.53F, Secs. 4(a), (c) (part), 5, as
13 added Acts 75th Leg., R.S., Ch. 683.)

14 Source Law

15 Sec. 4. (a) A health benefit plan that
16 provides benefits for a family member of the insured
17 shall provide coverage for each covered child
18 described by Section 5 of this article for:

19 (1) a screening test for hearing loss from
20 birth through the date the child is 30 days old, as
21 provided by Chapter 47, Health and Safety Code; and

22 (2) necessary diagnostic follow-up care
23 related to the screening test from birth through the
24 date the child is 24 months old.

25 (c) . . . This section does not require the
26 issuer of a health benefit plan to provide coverage
27 under this section for the child of a resident of this
28 state who:

29 (1) is employed outside of this state; and

30 (2) is covered under a health benefit plan
31 maintained for the individual by the individual's
32 employer as an employment benefit.

33 Sec. 5. A child is entitled to benefits under
34 this article if the child, as a result of the child's
35 relationship to an enrollee in the health benefit
36 plan, would be entitled to benefits under an accident
37 and sickness insurance policy under Subsection (K),
38 (L), or (M), Section 2, Chapter 397, Acts of the 54th
39 Legislature, 1955 (Article 3.70-2, Vernon's Texas
40 Insurance Code).

41 Revisor's Note

42 Section 4(a), V.T.I.C. Article 21.53F, as added
43 by Chapter 683, Acts of the 75th Legislature, Regular
44 Session, 1997, refers to coverage for a family member
45 of the "insured." The revised law adds a reference to

1 "enrollee" for the reason stated in Revisor's Note (2)
2 to Section 1367.053.

3 Revised Law

4 Sec. 1367.104. COPAYMENT OR COINSURANCE REQUIREMENT
5 PERMITTED; DEDUCTIBLE REQUIREMENT OR DOLLAR LIMIT PROHIBITED;
6 NOTICE REQUIRED. (a) Coverage required under this subchapter:

7 (1) may be subject to a copayment or coinsurance
8 requirement; and

9 (2) may not be subject to a deductible requirement or a
10 dollar limit.

11 (b) The requirements of this section must be stated in the
12 coverage document. (V.T.I.C. Art. 21.53F, Sec. 6(b), as added Acts
13 75th Leg., R.S., Ch. 683.)

14 Source Law

15 (b) Benefits required under Section 4 of this
16 article may be subject to copayment and coinsurance
17 requirements, but may not be subject to a deductible
18 requirement or dollar limit. The requirements of this
19 subsection must be stated in the coverage document.

20 Revised Law

21 Sec. 1367.105. RULES. The commissioner may adopt rules
22 necessary to implement this subchapter. (V.T.I.C. Art. 21.53F,
23 Secs. 4(b), 7, as added Acts 75th Leg., R.S., Ch. 683.)

24 Source Law

25 [Sec. 4]
26 (b) The commissioner may adopt rules to
27 implement the requirement of this section.

28 Sec. 7. The commissioner may adopt rules as
29 necessary to implement this article.

30 [Sections 1367.106-1367.150 reserved for expansion]

31 SUBCHAPTER D. CHILD CRANIOFACIAL ABNORMALITIES

32 Revised Law

33 Sec. 1367.151. APPLICABILITY OF SUBCHAPTER. This
34 subchapter applies only to a health benefit plan that:

35 (1) provides benefits for medical or surgical expenses
36 incurred as a result of a health condition, accident, or sickness,
37 including:

1 (A) an individual, group, blanket, or franchise
2 insurance policy or insurance agreement, a group hospital service
3 contract, or an individual or group evidence of coverage that is
4 offered by:

5 (i) an insurance company;

6 (ii) a group hospital service corporation
7 operating under Chapter 842;

8 (iii) a fraternal benefit society operating
9 under Chapter 885;

10 (iv) a stipulated premium company operating
11 under Chapter 884; or

12 (v) a health maintenance organization
13 operating under Chapter 843; and

14 (B) to the extent permitted by the Employee
15 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et
16 seq.), a health benefit plan that is offered by:

17 (i) a multiple employer welfare arrangement
18 as defined by Section 3 of that Act;

19 (ii) an entity not authorized under this
20 code or another insurance law of this state that contracts directly
21 for health care services on a risk-sharing basis, including a
22 capitation basis; or

23 (iii) another analogous benefit
24 arrangement; or

25 (2) is offered by an approved nonprofit health
26 corporation that holds a certificate of authority under Chapter
27 844. (V.T.I.C. Art. 21.53W, Sec. 2(a).)

28 Source Law

29 Sec. 2. (a) This article applies only to a
30 health benefit plan that:

31 (1) provides benefits for medical or
32 surgical expenses incurred as a result of a health
33 condition, accident, or sickness, including:

34 (A) an individual, group, blanket, or
35 franchise insurance policy or insurance agreement, a
36 group hospital service contract, or an individual or
37 group evidence of coverage that is offered by:

38 (i) an insurance company;

39 (ii) a group hospital service

1 corporation operating under Chapter 20 of this code;
2 (iii) a fraternal benefit
3 society operating under Chapter 10 of this code;
4 (iv) a stipulated premium
5 insurance company operating under Chapter 22 of this
6 code; or
7 (v) a health maintenance
8 organization operating under the Texas Health
9 Maintenance Organization Act (Chapter 20A, Vernon's
10 Texas Insurance Code); or
11 (B) to the extent permitted by the
12 Employee Retirement Income Security Act of 1974 (29
13 U.S.C. Section 1001 et seq.), a health benefit plan
14 that is offered by:
15 (i) a multiple employer welfare
16 arrangement as defined by Section 3, Employee
17 Retirement Income Security Act of 1974 (29 U.S.C.
18 Section 1002);
19 (ii) any other entity not
20 licensed under this code or another insurance law of
21 this state that contracts directly for health care
22 services on a risk-sharing basis, including an entity
23 that contracts for health care services on a
24 capitation basis; or
25 (iii) another analogous benefit
26 arrangement; or
27 (2) is offered by an approved nonprofit
28 health corporation that is certified under Section
29 5.01(a), Medical Practice Act (Article 4495b, Vernon's
30 Texas Civil Statutes), and that holds a certificate of
31 authority issued by the commissioner under Article
32 21.52F of this code.

33 Revisor's Note

34 (1) Section 2(a), V.T.I.C. Article 21.53W,
35 refers to a health benefit plan offered by an entity
36 that is not "licensed" under the Insurance Code or
37 another insurance law of this state. The revised law
38 substitutes "authorized" for "licensed" for
39 consistency with terminology used throughout this
40 code.

41 (2) Section 2(a), V.T.I.C. Article 21.53W,
42 refers to an approved nonprofit health corporation
43 that is "certified under Section 5.01(a), Medical
44 Practice Act," and holds a certificate of authority
45 "issued by the commissioner under Article 21.52F."
46 The revised law omits the reference to certification
47 under Section 5.01(a), Medical Practice Act, and the
48 reference to the commissioner issuing the certificate
49 of authority for the reasons stated in the revisor's
50 note to Section 1367.051.

1 Revised Law

2 Sec. 1367.152. EXCEPTION. This subchapter does not apply
3 to:

4 (1) a plan that provides coverage:

5 (A) only for a specified disease or for another
6 limited benefit;

7 (B) only for accidental death or dismemberment;

8 (C) for wages or payments in lieu of wages for a
9 period during which an employee is absent from work because of
10 sickness or injury;

11 (D) as a supplement to a liability insurance
12 policy;

13 (E) for credit insurance;

14 (F) only for dental or vision care; or

15 (G) only for indemnity for hospital confinement
16 or other hospital expenses;

17 (2) a small employer health benefit plan written under
18 Chapter 1501;

19 (3) a Medicare supplemental policy as defined by
20 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

21 (4) a workers' compensation insurance policy;

22 (5) medical payment insurance coverage provided under
23 a motor vehicle insurance policy; or

24 (6) a long-term care insurance policy, including a
25 nursing home fixed indemnity policy, unless the commissioner
26 determines that the policy provides benefit coverage so
27 comprehensive that the policy is a health benefit plan as described
28 by Section 1367.151. (V.T.I.C. Art. 21.53W, Sec. 2(b).)

29 Source Law

30 (b) This article does not apply to:

31 (1) a plan that provides coverage:

32 (A) only for a specified disease or
33 other limited benefit;

34 (B) only for accidental death or
35 dismemberment;

36 (C) for wages or payments in lieu of
37 wages for a period during which an employee is absent
38 from work because of sickness or injury;

1 (D) as a supplement to liability
2 insurance;
3 (E) for credit insurance;
4 (F) only for dental or vision care;
5 or
6 (G) only for indemnity for hospital
7 confinement or other hospital expenses;
8 (2) a small employer health benefit plan
9 written under Chapter 26 of this code;
10 (3) a Medicare supplemental policy as
11 defined by Section 1882(g)(1), Social Security Act (42
12 U.S.C. Section 1395ss);
13 (4) workers' compensation insurance
14 coverage;
15 (5) medical payment insurance issued as
16 part of a motor vehicle insurance policy; or
17 (6) a long-term care policy, including a
18 nursing home fixed indemnity policy, unless the
19 commissioner determines that the policy provides
20 benefit coverage so comprehensive that the policy is a
21 health benefit plan as described by Subsection (a) of
22 this section.

23 Revised Law

24 Sec. 1367.153. RECONSTRUCTIVE SURGERY FOR CRANIOFACIAL
25 ABNORMALITIES; DEFINITION REQUIRED. A health benefit plan that
26 provides coverage for a child who is younger than 18 years of age
27 must define "reconstructive surgery for craniofacial
28 abnormalities" under the plan to mean surgery to improve the
29 function of, or to attempt to create a normal appearance of, an
30 abnormal structure caused by congenital defects, developmental
31 deformities, trauma, tumors, infections, or disease. (V.T.I.C.
32 Art. 21.53W, Sec. 3.)

33 Source Law

34 Sec. 3. A health benefit plan that provides
35 benefits to a child who is younger than 18 years of age
36 must define reconstructive surgery for craniofacial
37 abnormalities under the plan to mean surgery to
38 improve the function of, or to attempt to create a
39 normal appearance of, an abnormal structure caused by
40 congenital defects, developmental deformities,
41 trauma, tumors, infections, or disease.

42 Revised Law

43 Sec. 1367.154. RULES. The commissioner shall adopt rules
44 necessary to administer this subchapter. (V.T.I.C. Art. 21.53W,
45 Sec. 4.)

46 Source Law

47 Sec. 4. The commissioner shall adopt rules as
48 necessary to administer this article.

1 Revisor's Note
2 (End of Subchapter)

3 (1) Section 1(1), V.T.I.C. Article 21.53W,
4 defines "enrollee." The revised law omits the
5 definition as unnecessary because the defined term is
6 not used in the revision of Article 21.53W. The
7 omitted law reads:

8 Art. 21.53W

9 Sec. 1. In this article:

10 (1) "Enrollee" means an
11 individual enrolled in a health benefit
12 plan.

13 (2) Section 1(2), V.T.I.C. Article 21.53W,
14 defines "health benefit plan." The revised law omits
15 the definition as unnecessary because Section 2 of
16 that article, revised as Sections 1367.151 and
17 1367.152, specifies the types of health benefit plans
18 to which this subchapter applies, and thus the defined
19 term is not helpful to the reader. The omitted law
20 reads:

21 (2) "Health benefit plan" means
22 a plan described by Section 2(a) of this
23 article.

24 Revisor's Note
25 (End of Chapter)

26 Section 1, V.T.I.C. Article 21.53F, as added by
27 Chapter 683, Acts of the 75th Legislature, Regular
28 Session, 1997, defines "health benefit plan." The
29 revised law omits the definition as unnecessary
30 because Section 2 of that article, revised as Sections
31 1367.051, 1367.052, 1367.101, and 1367.102, specify
32 the types of health benefit plans to which Subchapters
33 B and C apply, and thus the defined term is not helpful
34 to the reader. The omitted law reads:

35 Art. 21.53F

36 Sec. 1. In this article, "health
37 benefit plan" means a plan described by
38 Section 2 of this article.

1 CHAPTER 1368. AVAILABILITY OF CHEMICAL DEPENDENCY COVERAGE

2 Sec. 1368.001. DEFINITIONS 1025

3 Sec. 1368.002. APPLICABILITY OF CHAPTER 1027

4 Sec. 1368.003. EXCEPTION. 1028

5 Sec. 1368.004. COVERAGE REQUIRED 1031

6 Sec. 1368.005. MINIMUM COVERAGE REQUIREMENTS 1031

7 Sec. 1368.006. LIMITATION ON COVERAGE 1033

8 Sec. 1368.007. TREATMENT STANDARDS 1033

9 Sec. 1368.008. USE OF ENDORSEMENT OR RIDER TO COMPLY

10 WITH CHAPTER 1035

11 CHAPTER 1368. AVAILABILITY OF CHEMICAL DEPENDENCY COVERAGE

12 Revised Law

13 Sec. 1368.001. DEFINITIONS. In this chapter:

14 (1) "Chemical dependency" means the abuse of, a
 15 psychological or physical dependence on, or an addiction to alcohol
 16 or a controlled substance.

17 (2) "Chemical dependency treatment center" means a
 18 facility that provides a program for the treatment of chemical
 19 dependency under a written treatment plan approved and monitored by
 20 a physician and that is:

21 (A) affiliated with a hospital under a
 22 contractual agreement with an established system for patient
 23 referral;

24 (B) accredited as a chemical dependency
 25 treatment center by the Joint Commission on Accreditation of
 26 Healthcare Organizations;

27 (C) licensed as a chemical dependency treatment
 28 program by the Texas Commission on Alcohol and Drug Abuse; or

29 (D) licensed, certified, or approved as a
 30 chemical dependency treatment program or center by another state
 31 agency.

32 (3) "Controlled substance" means an abusable volatile
 33 chemical, as defined by Section 485.001, Health and Safety Code, or
 34 a substance designated as a controlled substance under Chapter 481,

1 Health and Safety Code. (V.T.I.C. Art. 3.51-9, Secs. 2, 2A(e).)

2 Source Law

3 Sec. 2. In this article:

4 (1) "Chemical dependency" means the abuse
5 of or psychological or physical dependence on or
6 addiction to alcohol or a controlled substance.

7 (2) "Controlled substance" means a toxic
8 inhalant or a substance designated as a controlled
9 substance in the Chapter 481, Health and Safety Code.

10 (3) "Toxic inhalant" means a volatile
11 chemical under Chapter 484, Health and Safety Code, or
12 abusable glue or aerosol paint under Section 485.001,
13 Health and Safety Code.

14 [Sec. 2A]

15 (e) For purposes of this section, the term
16 "chemical dependency treatment center" means a
17 facility which provides a program for the treatment of
18 chemical dependency pursuant to a written treatment
19 plan approved and monitored by a physician and which
20 facility is also:

21 (1) affiliated with a hospital under a
22 contractual agreement with an established system for
23 patient referral; or

24 (2) accredited as such a facility by the
25 Joint Commission on Accreditation of Hospitals; or

26 (3) licensed as a chemical dependency
27 treatment program by the Texas Commission on Alcohol
28 and Drug Abuse; or

29 (4) licensed, certified, or approved as a
30 chemical dependency treatment program or center by any
31 other state agency having legal authority to so
32 license, certify, or approve.

33 Revisor's Note

34 (1) Section 2(3), V.T.I.C. Article 3.51-9,
35 defines "toxic inhalant" to mean a volatile chemical
36 under Chapter 484, Health and Safety Code, or an
37 abusable glue or aerosol paint under Section 485.001,
38 Health and Safety Code. Chapter 459, Acts of the 77th
39 Legislature, Regular Session, 2001, amended Section
40 484.002, Health and Safety Code, which designates
41 certain chemicals as volatile chemicals. However,
42 Chapter 1463, Acts of the 77th Legislature, Regular
43 Session, 2001, repealed Chapter 484, Health and
44 Safety Code, and amended Section 485.001, Health and
45 Safety Code, by substituting the term "abusable
46 volatile chemical" for the defined term "abusable glue
47 or aerosol paint." Section 311.025, Government Code
48 (Code Construction Act), provides that "[i]f the

1 amendments [to the same statute enacted in the same
2 session of the legislature] are irreconcilable, the
3 latest in date of enactment prevails" and further
4 provides a method for determining the latest in date of
5 enactment. Under this method, Chapter 1463 prevails
6 over Chapter 459. Consequently, the revised law
7 substitutes "abusable volatile chemical as defined by
8 Section 485.001, Health and Safety Code," for "toxic
9 inhalant" and the definition of "toxic inhalant"
10 provided by Section 2(3), V.T.I.C. Article 3.51-9. In
11 addition, the revised law incorporates the substance
12 of the definition of "abusable volatile chemical" into
13 the definition of "controlled substance" provided by
14 Section 2(2), V.T.I.C. Article 3.51-9, revised as
15 Section 1368.001(3), because that is the only other
16 use of the term "toxic inhalant," revised as "abusable
17 volatile chemical," in V.T.I.C. Article 3.51-9.

18 (2) Section 2A(e)(2), V.T.I.C. Article 3.51-9,
19 refers to the "Joint Commission on Accreditation of
20 Hospitals." The proper name of that organization is
21 the Joint Commission on Accreditation of Healthcare
22 Organizations. The revised law is drafted
23 accordingly.

24 (3) Section 2A(e)(4), V.T.I.C. Article 3.51-9,
25 refers to a facility licensed, certified, or approved
26 as a chemical dependency treatment program or center
27 by a state agency "having legal authority to so
28 license, certify, or approve." The revised law omits
29 the quoted language as unnecessary because only an
30 authorized agency may effectively license, certify, or
31 approve a treatment program or center.

32 Revised Law

33 Sec. 1368.002. APPLICABILITY OF CHAPTER. This chapter
34 applies only to a group health benefit plan that provides hospital

1 and medical coverage or services on an expense incurred, service,
2 or prepaid basis, including a group insurance policy or contract or
3 self-funded or self-insured plan or arrangement that is offered in
4 this state by:

5 (1) an insurer;

6 (2) a group hospital service corporation operating
7 under Chapter 842;

8 (3) a health maintenance organization operating under
9 Chapter 843; or

10 (4) an employer, trustee, or other self-funded or
11 self-insured plan or arrangement. (V.T.I.C. Art. 3.51-9, Sec.
12 2A(a) (part).)

13 Source Law

14 Sec. 2A. (a) Insurers, nonprofit hospital and
15 medical service plan corporations subject to Chapter
16 20 of this code, health maintenance organizations
17 providing group health coverage, and all employer,
18 trustee, or other self-funded or self-insured plans or
19 arrangements transacting health insurance or
20 providing other health coverage or services in this
21 state . . . under such group insurance policies or
22 contracts and such plans or arrangements providing
23 hospital and medical coverage or services on an
24 expense incurred, service, or prepaid basis

25 Revisor's Note

26 Section 2A(a), V.T.I.C. Article 3.51-9, refers to
27 "nonprofit hospital and medical service plan
28 corporations" subject to V.T.I.C. Chapter 20, revised
29 as Chapter 842 of this code. The term most frequently
30 used to describe such a corporation is "group hospital
31 service corporation." Consequently, the revised law
32 substitutes "group hospital service corporation" for
33 "nonprofit hospital and medical service plan
34 corporations" to provide for consistent use of
35 terminology throughout this code.

36 Revised Law

37 Sec. 1368.003. EXCEPTION. This chapter does not apply to:

38 (1) an employer, trustee, or other self-funded or
39 self-insured plan or arrangement with 250 or fewer employees or

- 1 members;
- 2 (2) an individual insurance policy;
- 3 (3) an individual evidence of coverage issued by a
4 health maintenance organization;
- 5 (4) a health insurance policy that provides only:
- 6 (A) cash indemnity for hospital or other
7 confinement benefits;
- 8 (B) supplemental or limited benefit coverage;
- 9 (C) coverage for specified diseases or
10 accidents;
- 11 (D) disability income coverage; or
- 12 (E) any combination of those benefits or
13 coverages;
- 14 (5) a blanket insurance policy;
- 15 (6) a short-term travel insurance policy;
- 16 (7) an accident-only insurance policy;
- 17 (8) a limited or specified disease insurance policy;
- 18 (9) an individual conversion insurance policy or
19 contract;
- 20 (10) a policy or contract designed for issuance to a
21 person eligible for Medicare coverage or other similar coverage
22 under a state or federal government plan; or
- 23 (11) an evidence of coverage provided by a health
24 maintenance organization if the plan holder is the subject of a
25 collective bargaining agreement that was in effect on January 1,
26 1982, and that has not expired since that date. (V.T.I.C.
27 Art. 3.51-9, Secs. 2A(c), 3 (part).)

28 Source Law

29 [Sec. 2A]

30 (c) This section does not apply to any employer,
31 trustee, or any other self-funded or self-insured
32 plans or arrangements with 250 or fewer employees or
33 members, or any individual insurance policies
34 regardless of the method of solicitation or sale, or
35 any individual H.M.O. policies, or to any health
36 insurance policies that only provide cash indemnity
37 for hospital or other confinement benefits, or
38 supplemental or limited benefit coverage, or coverage
39 for specified diseases or accidents, or disability

1 income coverage, or any combination thereof.

2 Sec. 3. This Act applies to group policies or
3 contracts or coverage provided by health maintenance
4 organizations delivered or issued for delivery or
5 renewed, extended, or amended in this state on or after
6 January 1, 1982, or upon the expiration of a collective
7 bargaining agreement applicable to a particular
8 policyholder, whichever is later; provided that this
9 Act does not apply to blanket, short-term travel,
10 accident only, limited or specified disease,
11 individual conversion policies or contracts, nor to
12 policies or contracts designed for issuance to persons
13 eligible for coverage under Title XVIII of the Social
14 Security Act, known as Medicare, or any other similar
15 coverage under state or federal governmental
16 plans. . . .

17 Revisor's Note

18 (1) Section 2A(c), V.T.I.C. Article 3.51-9,
19 provides that the section does not apply to "any
20 individual insurance policies regardless of the method
21 of solicitation or sale." The revised law omits
22 "regardless of the method of solicitation or sale"
23 because, in context, it is unnecessary and does not add
24 to the clear meaning of the law. A policy is either an
25 individual policy or it is not, and the method of
26 solicitation or sale is irrelevant to that
27 determination.

28 (2) Section 2A(c), V.T.I.C. Article 3.51-9,
29 refers to health maintenance organization "policies."
30 The term most frequently used to describe the type of
31 coverage document issued by a health maintenance
32 organization is "evidence of coverage." Consequently,
33 the revised law substitutes "evidence of coverage" for
34 "policies" to provide for consistent use of
35 terminology throughout this code. Comparable changes
36 have been made throughout this chapter.

37 (3) Section 3, V.T.I.C. Article 3.51-9,
38 provides that the article applies to "group policies
39 or contracts or coverage provided by health
40 maintenance organizations delivered or issued for
41 delivery or renewed, extended, or amended in this

1 state on or after January 1, 1982." The revised law
2 omits the provision as obsolete; any policy or
3 contract now in effect would have been delivered,
4 issued, renewed, extended, or amended on or after
5 January 1, 1982.

6 (4) Section 3, V.T.I.C. Article 3.51-9, refers
7 to "Title XVIII of the Social Security Act, known as
8 Medicare." The revised law omits the reference to
9 "Title XVIII of the Social Security Act" as
10 unnecessary because "Medicare" is commonly used in
11 other statutes of the state without an accompanying
12 citation, and its meaning is unambiguous.

13 Revised Law

14 Sec. 1368.004. COVERAGE REQUIRED. (a) A group health
15 benefit plan shall provide coverage for the necessary care and
16 treatment of chemical dependency.

17 (b) Coverage required under this section may be provided:

18 (1) directly by the group health benefit plan issuer;

19 or

20 (2) by another entity, including a single service
21 health maintenance organization, under contract with the group
22 health benefit plan issuer. (V.T.I.C. Art. 3.51-9, Sec. 2A(a)
23 (part).)

24 Source Law

25 (a) [Insurers, nonprofit hospital and medical
26 service plan corporations subject to Chapter 20 of
27 this code, health maintenance organizations providing
28 group health coverage, and all employer, trustee, or
29 other self-funded or self-insured plans or
30 arrangements transacting health insurance or
31 providing other health coverage or services in this
32 state] shall provide, directly or by contract with
33 other entities, including a single service health
34 maintenance organization, . . . benefits for the
35 necessary care and treatment of chemical
36 dependency

37 Revised Law

38 Sec. 1368.005. MINIMUM COVERAGE REQUIREMENTS. (a) Except
39 as provided by Subsection (b), coverage required under this

1 chapter:

2 (1) may not be less favorable than coverage provided
3 for physical illness generally under the plan; and

4 (2) shall be subject to the same durational limits,
5 dollar limits, deductibles, and coinsurance factors that apply to
6 coverage provided for physical illness generally under the plan.

7 (b) A group health benefit plan may set dollar or durational
8 limits for coverage required under this chapter that are less
9 favorable than for coverage provided for physical illness generally
10 under the plan if those limits are sufficient to provide
11 appropriate care and treatment under the guidelines and standards
12 adopted under Section 1368.007. If guidelines and standards
13 adopted under Section 1368.007 are not in effect, the dollar and
14 durational limits may not be less favorable than for physical
15 illness generally.

16 (c) This section does not require payment of a usual,
17 customary, and reasonable rate for treatment of a covered
18 individual if a health maintenance organization or preferred
19 provider organization establishes a negotiated rate for the
20 locality in which the covered individual customarily receives care.
21 (V.T.I.C. Art. 3.51-9, Sec. 2A(a) (part).)

22 Source Law

23 (a) [Insurers, nonprofit hospital and medical
24 service plan corporations subject to Chapter 20 of
25 this code, health maintenance organizations providing
26 group health coverage, and all employer, trustee, or
27 other self-funded or self-insured plans or
28 arrangements transacting health insurance or
29 providing other health coverage or services in this
30 state shall provide] . . . benefits for the necessary
31 care and treatment of chemical dependency that are not
32 less favorable than for physical illness generally,
33 subject to the same durational limits, dollar limits,
34 deductibles, and coinsurance factors. An entity under
35 this section may set dollar or durational limits in a
36 policy, contract, plan, or arrangement providing
37 benefits under this article which are less favorable
38 than for physical illness generally if such limits are
39 sufficient to provide appropriate care and treatment
40 under the guidelines and standards adopted under
41 Subsection (d) of this section.

42 This section shall not be construed to require
43 that a usual, customary, and reasonable rate be paid
44 when a negotiated rate is established by a health
45 maintenance organization or preferred provider

1 organization for the locality in which the covered
2 individual customarily receives care.

3 If no guidelines or standards are in effect under
4 Subsection (d), such limits shall be no less favorable
5 than for physical illness generally.

6 Revised Law

7 Sec. 1368.006. LIMITATION ON COVERAGE. (a) In this
8 section, "treatment series" means a planned, structured, and
9 organized program to promote chemical-free status that:

10 (1) may include different facilities or modalities;
11 and

12 (2) is completed when the covered individual:

13 (A) is, on medical advice, discharged from:

14 (i) inpatient detoxification;

15 (ii) inpatient rehabilitation or
16 treatment;

17 (iii) partial hospitalization or intensive
18 outpatient treatment; or

19 (iv) a series of those levels of treatments
20 without a lapse in treatment; or

21 (B) fails to materially comply with the treatment
22 program for a period of 30 days.

23 (b) Notwithstanding Section 1368.005, coverage required
24 under this chapter is limited to a lifetime maximum of three
25 separate treatment series for each covered individual. (V.T.I.C.
26 Art. 3.51-9, Sec. 2A(b).)

27 Source Law

28 (b) Notwithstanding Subsection (a) of this
29 section, coverage for chemical dependency is limited
30 to a lifetime maximum of three separate series of
31 treatments for each covered individual.

32 A series of treatments is a planned, structured,
33 and organized program to promote chemical free status
34 which may include different facilities or modalities
35 and is complete when the covered individual is
36 discharged on medical advice from inpatient
37 detoxification, inpatient rehabilitation/treatment,
38 partial hospitalization or intensive outpatient or a
39 series of these levels of treatments without a lapse in
40 treatment or when a person fails to materially comply
41 with the treatment program for a period of 30 days.

42 Revised Law

43 Sec. 1368.007. TREATMENT STANDARDS. (a) Coverage provided

1 under this chapter for necessary care and treatment in a chemical
2 dependency treatment center must be provided as if the care and
3 treatment were provided in a hospital.

4 (b) The department by rule shall adopt standards formulated
5 and approved by the department and the Texas Commission on Alcohol
6 and Drug Abuse for use by insurers, other third-party reimbursement
7 sources, and chemical dependency treatment centers.

8 (c) Standards adopted under this section must provide for:

9 (1) reasonable control of costs necessary for
10 inpatient and outpatient treatment of chemical dependency,
11 including guidelines for treatment periods; and

12 (2) appropriate utilization review of treatment as
13 well as necessary extensions of treatment.

14 (d) Coverage required under this chapter is subject to the
15 standards adopted under this section. (V.T.I.C. Art. 3.51-9, Sec.
16 2A(d).)

17 Source Law

18 (d) Any benefits so provided shall be determined
19 as if necessary care and treatment in a chemical
20 dependency treatment center were care and treatment in
21 a hospital. The Texas Department of Insurance and the
22 Texas Commission on Alcohol and Drug Abuse shall
23 formulate standards for use by insurers, other third
24 party reimbursement sources, and chemical dependency
25 treatment centers for the reasonable control of costs
26 necessary for inpatient and outpatient treatment of
27 chemical dependency, including guidelines for
28 treatment periods. The standards shall provide for
29 appropriate utilization review of treatment as well as
30 necessary extensions of treatment. The department by
31 rule shall adopt the standards as approved by both the
32 department and the Texas Commission on Alcohol and
33 Drug Abuse, and those standards are applicable to the
34 provision of all services under this section. On
35 adoption of standards or rules by the department under
36 this section, benefits provided herein shall be
37 subject to those standards or rules.

38 Revisor's Note

39 Section 2A(d), V.T.I.C. Article 3.51-9, provides
40 that the "services" and "benefits" provided under that
41 section are subject to certain standards adopted by
42 the Texas Department of Insurance. The revised law
43 substitutes "coverage" for "services" and "benefits"

1 to provide for consistent use of terminology
2 throughout this chapter.

3 Revised Law

4 Sec. 1368.008. USE OF ENDORSEMENT OR RIDER TO COMPLY WITH
5 CHAPTER. A group health benefit plan issuer that uses a policy
6 form approved by the commissioner before November 10, 1981, may use
7 an endorsement or rider to comply with this chapter if the
8 endorsement or rider is approved by the commissioner as complying
9 with this chapter and other provisions of this code. (V.T.I.C.
10 Art. 3.51-9, Sec. 3 (part).)

11 Source Law

12 Sec. 3. . . . With respect to any policy forms
13 approved by the State Board of Insurance prior to the
14 effective date of this Act, an insurer is authorized to
15 achieve compliance with this Act by the use of
16 endorsements or riders provided such endorsements or
17 riders are approved by the State Board of Insurance as
18 being in compliance with this Act and other provisions
19 of the Texas Insurance Code.

20 Revisor's Note

21 (1) Section 3, V.T.I.C. Article 3.51-9, refers
22 to the "State Board of Insurance." Chapter 685, Acts
23 of the 73rd Legislature, Regular Session, 1993,
24 abolished the State Board of Insurance and transferred
25 its functions to the commissioner of insurance and the
26 Texas Department of Insurance. The reference to the
27 State Board of Insurance has been changed
28 appropriately.

29 (2) Section 3, V.T.I.C. Article 3.51-9, refers
30 to an "insurer." The revised law substitutes "group
31 health benefit plan issuer" for "insurer" to provide
32 for consistent use of terminology throughout this
33 chapter.

34 (3) Section 3, V.T.I.C. Article 3.51-9, refers
35 to "the effective date of this Act." The effective
36 date of the act that added that section is November 10,
37 1981. Consequently, the revised law substitutes

1 "November 10, 1981," for the quoted language.

2 Revisor's Note
3 (End of Chapter)

4 Section 1, V.T.I.C. Article 3.51-9, states the
5 purpose of that article. The revised law omits the
6 provision as unnecessary because it is nonsubstantive
7 and because the legislative purpose in enacting the
8 article is clear from the other, substantive
9 provisions of the article revised in this chapter. The
10 omitted law reads:

11 Art. 3.51-9

12 Sec. 1. The purpose of this article
13 is to provide consumers with benefits for
14 the care and treatment of chemical
15 dependency in group health insurance
16 policies or contracts, group health
17 coverage provided by health maintenance
18 organizations, and all self-funded or
19 self-insured plans (but excluding those
20 self-funded or self-insured plans with 250
21 or fewer employees or members), that
22 provide basic hospital, surgical, or major
23 medical expense benefits or coverages or
24 any combination of these coverages, but
25 excluding all individual insurance
26 policies, and any individual H.M.O.
27 policies, regardless of the method of
28 solicitation or sale, and excluding all
29 health insurance policies that only provide
30 cash indemnity for hospital or other
31 confinement benefits, or supplemental or
32 limited benefit coverage, or coverage for
33 specified diseases or accidents, or
34 disability income coverage, or any
35 combination thereof.

36 CHAPTER 1369. BENEFITS RELATED TO PRESCRIPTION DRUGS
37 AND DEVICES AND RELATED SERVICES

38 SUBCHAPTER A. COVERAGE OF PRESCRIPTION DRUGS IN GENERAL

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1 CHAPTER 1369. BENEFITS RELATED TO PRESCRIPTION DRUGS
2 AND DEVICES AND RELATED SERVICES
3 SUBCHAPTER A. COVERAGE OF PRESCRIPTION DRUGS IN GENERAL

4 Revised Law

5 Sec. 1369.001. DEFINITIONS. In this subchapter:

6 (1) "Contraindication" means the potential for, or the
7 occurrence of:

8 (A) an undesirable change in the therapeutic
9 effect of a prescribed drug because of the presence of a disease
10 condition in the patient for whom the drug is prescribed; or

11 (B) a clinically significant adverse effect of a
12 prescribed drug on a disease condition of the patient for whom the
13 drug is prescribed.

14 (2) "Drug" has the meaning assigned by Section
15 551.003, Occupations Code.

16 (3) "Indication" means a symptom, cause, or occurrence
17 in a disease that points out the cause, diagnosis, course of
18 treatment, or prognosis of the disease.

19 (4) "Peer-reviewed medical literature" means
20 scientific studies published in a peer-reviewed national
21 professional journal. (V.T.I.C. Art. 21.53M, Secs. 1(1), (2), (4),
22 (5).)

23 Source Law

24 Art. 21.53M

25 Sec. 1. In this article:

26 (1) "Contraindication" means the
27 potential for, or the occurrence of, an undesirable
28 alteration of the therapeutic effect of a prescribed
29 drug prescription because of the presence, in the
30 patient for whom it is prescribed, of a disease
31 condition, or the potential for, or the occurrence of,
32 a clinically significant adverse effect of the drug on
33 the patient's disease condition.

34 (2) "Drug" has the meaning assigned by
35 Section 5, Texas Pharmacy Act (Article 4542a-1,
36 Vernon's Texas Civil Statutes).

37 (4) "Indication" means any symptom, cause,
38 or occurrence in a disease that points out the cause,
39 diagnosis, course of treatment, or prognosis of the
40 disease.

41 (5) "Peer-reviewed medical literature"
42 means published scientific studies in any
43 peer-reviewed national professional journal.

1 Revisor's Note

2 (1) Section 1(2), V.T.I.C. Article 21.53M,
3 refers to Section 5, Texas Pharmacy Act (Article
4 4542a-1, Vernon's Texas Civil Statutes). That statute
5 was codified in 1999 as Section 551.003, Occupations
6 Code. The revised law is drafted accordingly.

7 (2) Section 1(3), V.T.I.C. Article 21.53M,
8 defines "health benefit plan." The revised law omits
9 the definition as unnecessary because Section 2 of
10 that article, revised as Sections 1369.002 and
11 1369.003, specifies the types of health benefit plans
12 to which this subchapter applies, and thus the defined
13 term is not helpful to the reader. The omitted law
14 reads:

15 (3) "Health benefit plan" means
16 a plan described by Section 2 of this
17 article.

18 Revised Law

19 Sec. 1369.002. APPLICABILITY OF SUBCHAPTER. This
20 subchapter applies only to a health benefit plan that provides
21 benefits for medical or surgical expenses incurred as a result of a
22 health condition, accident, or sickness, including an individual,
23 group, blanket, or franchise insurance policy or insurance
24 agreement, a group hospital service contract, or an individual or
25 group evidence of coverage or similar coverage document that is
26 offered by:

27 (1) an insurance company;

28 (2) a group hospital service corporation operating
29 under Chapter 842;

30 (3) a fraternal benefit society operating under
31 Chapter 885;

32 (4) a stipulated premium company operating under
33 Chapter 884;

34 (5) a reciprocal exchange operating under Chapter 942;

35 (6) a health maintenance organization operating under

1 Chapter 843;

2 (7) a multiple employer welfare arrangement that holds
3 a certificate of authority under Chapter 846; or

4 (8) an approved nonprofit health corporation that
5 holds a certificate of authority under Chapter 844. (V.T.I.C.
6 Art. 21.53M, Sec. 2(a).)

7 Source Law

8 Sec. 2. (a) This article applies only to a
9 health benefit plan that provides benefits for medical
10 or surgical expenses incurred as a result of a health
11 condition, accident, or sickness, including an
12 individual, group, blanket, or franchise insurance
13 policy or insurance agreement, a group hospital
14 service contract, or an individual or group evidence
15 of coverage or similar coverage document that is
16 offered by:

17 (1) an insurance company;

18 (2) a group hospital service corporation
19 operating under Chapter 20 of this code;

20 (3) a fraternal benefit society operating
21 under Chapter 10 of this code;

22 (4) a stipulated premium insurance company
23 operating under Chapter 22 of this code;

24 (5) a reciprocal exchange operating under
25 Chapter 19 of this code;

26 (6) a health maintenance organization
27 operating under the Texas Health Maintenance
28 Organization Act (Chapter 20A, Vernon's Texas
29 Insurance Code);

30 (7) a multiple employer welfare
31 arrangement that holds a certificate of authority
32 under Article 3.95-2 of this code; or

33 (8) an approved nonprofit health
34 corporation that holds a certificate of authority
35 issued by the commissioner under Article 21.52F of
36 this code.

37 Revisor's Note

38 Section 2(a)(8), V.T.I.C. Article 21.53M, refers
39 to an approved nonprofit health corporation that holds
40 a certificate of authority "issued by the
41 commissioner." The revised law omits the quoted
42 language as unnecessary because Article 21.52F,
43 revised as Chapter 844 of this code, requires the
44 commissioner to issue the certificate of authority.

45 Revised Law

46 Sec. 1369.003. EXCEPTION. This subchapter does not apply
47 to:

48 (1) a health benefit plan that provides coverage:

- 1 (A) only for a specified disease or for another
2 limited benefit;
- 3 (B) only for accidental death or dismemberment;
- 4 (C) for wages or payments in lieu of wages for a
5 period during which an employee is absent from work because of
6 sickness or injury;
- 7 (D) as a supplement to a liability insurance
8 policy;
- 9 (E) for credit insurance;
- 10 (F) only for dental or vision care;
- 11 (G) only for hospital expenses; or
- 12 (H) only for indemnity for hospital confinement;
- 13 (2) a small employer health benefit plan written under
14 Chapter 1501;
- 15 (3) a Medicare supplemental policy as defined by
16 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),
17 as amended;
- 18 (4) a workers' compensation insurance policy;
- 19 (5) medical payment insurance coverage provided under
20 a motor vehicle insurance policy; or
- 21 (6) a long-term care insurance policy, including a
22 nursing home fixed indemnity policy, unless the commissioner
23 determines that the policy provides benefit coverage so
24 comprehensive that the policy is a health benefit plan as described
25 by Section 1369.002. (V.T.I.C. Art. 21.53M, Sec. 2(b).)

26 Source Law

- 27 (b) This article does not apply to:
- 28 (1) a plan that provides coverage:
- 29 (A) only for a specified disease or
30 other limited benefit;
- 31 (B) only for accidental death or
32 dismemberment;
- 33 (C) for wages or payments in lieu of
34 wages for a period during which an employee is absent
35 from work because of sickness or injury;
- 36 (D) as a supplement to liability
37 insurance;
- 38 (E) for credit insurance;
- 39 (F) only for dental or vision care;
- 40 (G) only for hospital expenses; or
- 41 (H) only for indemnity for hospital

1 confinement;
2 (2) a small employer health benefit plan
3 written under Chapter 26 of this code;
4 (3) a Medicare supplemental policy as
5 defined by Section 1882(g)(1), Social Security Act (42
6 U.S.C. Section 1395ss), as amended;
7 (4) workers' compensation insurance
8 coverage;
9 (5) medical payment insurance coverage
10 issued as part of a motor vehicle insurance policy; or
11 (6) a long-term care policy, including a
12 nursing home fixed indemnity policy, unless the
13 commissioner determines that the policy provides
14 benefit coverage so comprehensive that the policy is a
15 health benefit plan as described by Subsection (a) of
16 this section.

17 Revised Law

18 Sec. 1369.004. COVERAGE REQUIRED. (a) A health benefit
19 plan that covers drugs must cover any drug prescribed to treat an
20 enrollee for a chronic, disabling, or life-threatening illness
21 covered under the plan if the drug:

22 (1) has been approved by the United States Food and
23 Drug Administration for at least one indication; and

24 (2) is recognized by the following for treatment of
25 the indication for which the drug is prescribed:

26 (A) a prescription drug reference compendium
27 approved by the commissioner for purposes of this section; or

28 (B) substantially accepted peer-reviewed medical
29 literature.

30 (b) Coverage of a drug required under Subsection (a) must
31 include coverage of medically necessary services associated with
32 the administration of the drug.

33 (c) A health benefit plan issuer may not, based on a
34 "medical necessity" requirement, deny coverage of a drug required
35 under Subsection (a) unless the reason for the denial is unrelated
36 to the legal status of the drug use.

37 (d) This section does not require a health benefit plan to
38 cover:

39 (1) experimental drugs that are not otherwise approved
40 for an indication by the United States Food and Drug
41 Administration;

42 (2) any disease or condition that is excluded from

1 coverage under the plan; or

2 (3) a drug that the United States Food and Drug
3 Administration has determined to be contraindicated for treatment
4 of the current indication. (V.T.I.C. Art. 21.53M, Sec. 3.)

5 Source Law

6 Sec. 3. (a) A health benefit plan that
7 provides coverage for drugs must provide coverage for
8 any drug prescribed to treat an enrollee for a covered
9 chronic, disabling, or life-threatening illness if the
10 drug:

11 (1) has been approved by the Food and Drug
12 Administration for at least one indication; and

13 (2) is recognized for treatment of the
14 indication for which the drug is prescribed in:

15 (A) a prescription drug reference
16 compendium approved by the commissioner for the
17 purpose of this article; or

18 (B) substantially accepted
19 peer-reviewed medical literature.

20 (b) Coverage of a drug required by this section
21 shall include coverage of medically necessary services
22 associated with the administration of the drug.

23 (c) A drug use that is covered under this
24 section may not be denied based on a "medical
25 necessity" requirement except for reasons that are
26 unrelated to the legal status of the drug use.

27 (d) This section does not require coverage for:

28 (1) experimental drugs not otherwise
29 approved for any indication by the Food and Drug
30 Administration; or

31 (2) any disease or condition that is
32 excluded from coverage under the plan.

33 (e) A health benefit plan is not required to
34 cover a drug the Food and Drug Administration has
35 determined to be contraindicated for treatment of the
36 current indication.

37 Revised Law

38 Sec. 1369.005. RULES. The commissioner may adopt rules to
39 implement this subchapter. (V.T.I.C. Art. 21.53M, Sec. 4.)

40 Source Law

41 Sec. 4. The commissioner may adopt rules to
42 implement this article.

43 [Sections 1369.006-1369.050 reserved for expansion]

44 SUBCHAPTER B. COVERAGE OF PRESCRIPTION DRUGS

45 SPECIFIED BY DRUG FORMULARY

46 Revised Law

47 Sec. 1369.051. DEFINITIONS. In this subchapter:

48 (1) "Drug formulary" means a list of drugs:

49 (A) for which a health benefit plan provides

1 coverage;

2 (B) for which a health benefit plan issuer
3 approves payment; or

4 (C) that a health benefit plan issuer encourages
5 or offers incentives for physicians to prescribe.

6 (2) "Enrollee" means an individual who is covered
7 under a group health benefit plan, including a covered dependent.

8 (3) "Physician" means a person licensed as a physician
9 by the Texas State Board of Medical Examiners.

10 (4) "Prescription drug" has the meaning assigned by
11 Section 551.003, Occupations Code. (V.T.I.C. Art. 21.52J, Secs.
12 1(1), (2), (4), (5).)

13 Source Law

14 Art. 21.52J

15 Sec. 1. In this article:

16 (1) "Drug formulary" means a list of drugs
17 for which a health benefit plan provides coverage,
18 approves payment, or encourages or offers incentives
19 for physicians to prescribe.

20 (2) "Enrollee" means an individual who is
21 covered under a group health benefit plan, including a
22 covered dependent.

23 (4) "Physician" means a person licensed as
24 a physician by the Texas State Board of Medical
25 Examiners.

26 (5) "Prescription drug" has the meaning
27 assigned by Section 5, Texas Pharmacy Act (Article
28 4542a-1, Vernon's Texas Civil Statutes).

29 Revisor's Note

30 (1) Section 1(3), V.T.I.C. Article 21.52J,
31 defines "group health benefit plan." The revised law
32 omits the definition as unnecessary because Section 2
33 of that article, revised as Sections 1369.052 and
34 1369.053, specifies the types of group health benefit
35 plans to which this subchapter applies, and thus the
36 defined term is not helpful to the reader. The omitted
37 law reads:

38 (3) "Group health benefit plan"
39 means a plan described by Section 2 of this
40 article.

41 (2) Section 1(5), V.T.I.C. Article 21.52J,

1 refers to Section 5, Texas Pharmacy Act (Article
2 4542a-1, Vernon's Texas Civil Statutes). That statute
3 was codified in 1999 as Section 551.003, Occupations
4 Code. The revised law is drafted accordingly.

5 Revised Law

6 Sec. 1369.052. APPLICABILITY OF SUBCHAPTER. This
7 subchapter applies only to a group health benefit plan that
8 provides benefits for medical or surgical expenses incurred as a
9 result of a health condition, accident, or sickness, including a
10 group, blanket, or franchise insurance policy or insurance
11 agreement, a group hospital service contract, or a group contract
12 or similar coverage document that is offered by:

- 13 (1) an insurance company;
- 14 (2) a group hospital service corporation operating
15 under Chapter 842;
- 16 (3) a fraternal benefit society operating under
17 Chapter 885;
- 18 (4) a stipulated premium company operating under
19 Chapter 884;
- 20 (5) a reciprocal exchange operating under Chapter 942;
- 21 (6) a health maintenance organization operating under
22 Chapter 843;
- 23 (7) a multiple employer welfare arrangement that holds
24 a certificate of authority under Chapter 846; or
- 25 (8) an approved nonprofit health corporation that
26 holds a certificate of authority under Chapter 844. (V.T.I.C.
27 Art. 21.52J, Sec. 2(a).)

28 Source Law

29 Sec. 2. (a) This article applies only to a
30 group health benefit plan that provides benefits for
31 medical or surgical expenses incurred as a result of a
32 health condition, accident, or sickness, including a
33 group, blanket, or franchise insurance policy or
34 insurance agreement, a group hospital service
35 contract, or a group contract or similar coverage
36 document that is offered by:

- 37 (1) an insurance company;
- 38 (2) a group hospital service corporation
39 operating under Chapter 20 of this code;

1 (3) a fraternal benefit society operating
2 under Chapter 10 of this code;

3 (4) a stipulated premium insurance company
4 operating under Chapter 22 of this code;

5 (5) a reciprocal exchange operating under
6 Chapter 19 of this code;

7 (6) a health maintenance organization
8 operating under the Texas Health Maintenance
9 Organization Act (Chapter 20A, Vernon's Texas
10 Insurance Code);

11 (7) a multiple employer welfare
12 arrangement that holds a certificate of authority
13 under Article 3.95-2 of this code; or

14 (8) an approved nonprofit health
15 corporation that holds a certificate of authority
16 issued by the commissioner under Article 21.52F of
17 this code.

18 Revisor's Note

19 Section 2(a)(8), V.T.I.C. Article 21.52J, refers
20 to an approved nonprofit health corporation that holds
21 a certificate of authority "issued by the
22 commissioner." The revised law omits the quoted
23 language for the reason stated in the revisor's note to
24 Section 1369.002.

25 Revised Law

26 Sec. 1369.053. EXCEPTION. This subchapter does not apply
27 to:

28 (1) a health benefit plan that provides coverage:

29 (A) only for a specified disease or for another
30 single benefit;

31 (B) only for accidental death or dismemberment;

32 (C) for wages or payments in lieu of wages for a
33 period during which an employee is absent from work because of
34 sickness or injury;

35 (D) as a supplement to a liability insurance
36 policy;

37 (E) for credit insurance;

38 (F) only for dental or vision care;

39 (G) only for hospital expenses; or

40 (H) only for indemnity for hospital confinement;

41 (2) a small employer health benefit plan written under
42 Chapter 1501;

1 (3) a Medicare supplemental policy as defined by
2 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),
3 as amended;

4 (4) a workers' compensation insurance policy;

5 (5) medical payment insurance coverage provided under
6 a motor vehicle insurance policy; or

7 (6) a long-term care insurance policy, including a
8 nursing home fixed indemnity policy, unless the commissioner
9 determines that the policy provides benefit coverage so
10 comprehensive that the policy is a health benefit plan as described
11 by Section 1369.052. (V.T.I.C. Art. 21.52J, Sec. 2(b).)

12 Source Law

13 (b) This article does not apply to:

14 (1) a plan that provides coverage:

15 (A) only for a specified disease or
16 other single benefit;

17 (B) only for accidental death or
18 dismemberment;

19 (C) for wages or payments in lieu of
20 wages for a period during which an employee is absent
21 from work because of sickness or injury;

22 (D) as a supplement to liability
23 insurance;

24 (E) for credit insurance;

25 (F) only for dental or vision care;

26 (G) only for hospital expenses; or

27 (H) only for indemnity for hospital
28 confinement;

29 (2) a small employer health benefit plan
30 written under Chapter 26 of this code;

31 (3) a Medicare supplemental policy as
32 defined by Section 1882(g)(1), Social Security Act (42
33 U.S.C. Section 1395ss), as amended;

34 (4) workers' compensation insurance
35 coverage;

36 (5) medical payment insurance coverage
37 issued as part of a motor vehicle insurance policy; or

38 (6) a long-term care policy, including a
39 nursing home fixed indemnity policy, unless the
40 commissioner determines that the policy provides
41 benefit coverage so comprehensive that the policy is a
42 health benefit plan as described by Subsection (a) of
43 this section.

44 Revised Law

45 Sec. 1369.054. NOTICE AND DISCLOSURE OF CERTAIN INFORMATION
46 REQUIRED. An issuer of a group health benefit plan that covers
47 prescription drugs and uses one or more drug formularies to specify
48 the prescription drugs covered under the plan shall:

49 (1) provide in plain language in the coverage

1 documentation provided to each enrollee:

2 (A) notice that the plan uses one or more drug
3 formularies;

4 (B) an explanation of what a drug formulary is;

5 (C) a statement regarding the method the issuer
6 uses to determine the prescription drugs to be included in or
7 excluded from a drug formulary;

8 (D) a statement of how often the issuer reviews
9 the contents of each drug formulary; and

10 (E) notice that an enrollee may contact the
11 issuer to determine whether a specific drug is included in a
12 particular drug formulary;

13 (2) disclose to an individual on request, not later
14 than the third business day after the date of the request, whether a
15 specific drug is included in a particular drug formulary; and

16 (3) notify an enrollee and any other individual who
17 requests information under this section that the inclusion of a
18 drug in a drug formulary does not guarantee that an enrollee's
19 health care provider will prescribe that drug for a particular
20 medical condition or mental illness. (V.T.I.C. Art. 21.52J, Sec.
21 3.)

22 Source Law

23 Sec. 3. A group health benefit plan that covers
24 prescription drugs and that uses one or more drug
25 formularies to specify which prescription drugs the
26 plan will cover shall:

27 (1) provide to each enrollee in plain
28 language in the coverage documentation provided to the
29 enrollee:

30 (A) notice that the plan uses one or
31 more drug formularies;

32 (B) an explanation of what a drug
33 formulary is;

34 (C) a statement regarding the method
35 the plan uses to determine which prescription drugs
36 are included in or excluded from a drug formulary;

37 (D) a statement of how often the plan
38 reviews the contents of each drug formulary; and

39 (E) notice that the enrollee may
40 contact the plan to find out if a specific drug is on a
41 particular drug formulary;

42 (2) disclose to any individual on request,
43 not later than the third business day after the date of
44 the request, whether a specific drug is on a particular
45 drug formulary; and

1 (3) notify an enrollee or any other
2 individual who requests information about a drug
3 formulary under this section that the presence of a
4 drug on a drug formulary does not guarantee that an
5 enrollee's health care provider will prescribe that
6 drug for a particular medical condition or mental
7 illness.

8 Revised Law

9 Sec. 1369.055. CONTINUATION OF COVERAGE REQUIRED; OTHER
10 DRUGS NOT PRECLUDED. (a) An issuer of a group health benefit plan
11 that covers prescription drugs shall offer to each enrollee at the
12 contracted benefit level and until the enrollee's plan renewal date
13 any prescription drug that was approved or covered under the plan
14 for a medical condition or mental illness, regardless of whether
15 the drug has been removed from the health benefit plan's drug
16 formulary before the plan renewal date.

17 (b) This section does not prohibit a physician or other
18 health professional who is authorized to prescribe a drug from
19 prescribing a drug that is an alternative to a drug for which
20 continuation of coverage is required under Subsection (a) if the
21 alternative drug is:

22 (1) covered under the group health benefit plan; and

23 (2) medically appropriate for the enrollee. (V.T.I.C.
24 Art. 21.52J, Sec. 4.)

25 Source Law

26 Sec. 4. (a) A group health benefit plan that
27 offers prescription drug benefits shall make a
28 prescription drug that was approved or covered for a
29 medical condition or mental illness available to each
30 enrollee at the contracted benefit level until the
31 enrollee's plan renewal date, regardless of whether
32 the prescribed drug has been removed from the health
33 benefit plan's drug formulary.

34 (b) This section does not preclude a physician
35 or other health professional authorized to prescribe a
36 drug from prescribing another drug covered by the
37 group health benefit plan that is medically
38 appropriate for the enrollee.

39 Revised Law

40 Sec. 1369.056. ADVERSE DETERMINATION. (a) The refusal of
41 a group health benefit plan issuer to provide benefits to an
42 enrollee for a prescription drug is an adverse determination for
43 purposes of Section 2, Article 21.58A, if:

1 (1) the drug is not included in a drug formulary used
2 by the group health benefit plan; and

3 (2) the enrollee's physician has determined that the
4 drug is medically necessary.

5 (b) The enrollee may appeal the adverse determination under
6 Sections 6 and 6A, Article 21.58A. (V.T.I.C. Art. 21.52J, Sec. 5.)

7 Source Law

8 Sec. 5. If a group health benefit plan, through
9 any of its employees or agents, refuses to provide
10 benefits to an enrollee for a drug that is not included
11 in a drug formulary and that the enrollee's physician
12 has determined is medically necessary, the refusal
13 constitutes an adverse determination for purposes of
14 Section 2, Article 21.58A of this code. An enrollee
15 may appeal the adverse determination under Sections 6
16 and 6A, Article 21.58A of this code.

17 Revisor's Note

18 Section 5, V.T.I.C. Article 21.52J, refers to a
19 refusal of a group health benefit plan "through any of
20 its employees or agents." The revised law omits the
21 reference to employees or agents as unnecessary
22 because an action taken by a group health benefit plan
23 is necessarily taken by an employee or agent of the
24 plan.

25 Revised Law

26 Sec. 1369.057. RULES. The commissioner may adopt rules to
27 implement this subchapter. (V.T.I.C. Art. 21.52J, Sec. 6.)

28 Source Law

29 Sec. 6. The commissioner may adopt rules to
30 implement this article.

31 [Sections 1369.058-1369.100 reserved for expansion]

32 SUBCHAPTER C. COVERAGE OF PRESCRIPTION CONTRACEPTIVE

33 DRUGS AND DEVICES AND RELATED SERVICES

34 Revised Law

35 Sec. 1369.101. DEFINITIONS. In this subchapter:

36 (1) "Enrollee" means a person who is entitled to
37 benefits under a health benefit plan.

38 (2) "Outpatient contraceptive service" means a

1 consultation, examination, procedure, or medical service that is
2 provided on an outpatient basis and that is related to the use of a
3 drug or device intended to prevent pregnancy. (V.T.I.C.
4 Art. 21.52L, Sec. 1, as added Acts 77th Leg., R.S., Ch. 1106.)

5 Source Law

6 Art. 21.52L

7 Sec. 1. In this article:

8 (1) "Enrollee" means any person who is
9 entitled to benefits under a health benefit plan.

10 (2) "Outpatient contraceptive service"
11 means a consultation, examination, procedure, or
12 medical service that is provided on an outpatient
13 basis and that is related to the use of a drug or device
14 intended to prevent pregnancy.

15 Revised Law

16 Sec. 1369.102. APPLICABILITY OF SUBCHAPTER. This
17 subchapter applies only to a health benefit plan, including a small
18 employer health benefit plan written under Chapter 1501, that
19 provides benefits for medical or surgical expenses incurred as a
20 result of a health condition, accident, or sickness, including an
21 individual, group, blanket, or franchise insurance policy or
22 insurance agreement, a group hospital service contract, or an
23 individual or group evidence of coverage or similar coverage
24 document that is offered by:

25 (1) an insurance company;

26 (2) a group hospital service corporation operating
27 under Chapter 842;

28 (3) a fraternal benefit society operating under
29 Chapter 885;

30 (4) a stipulated premium company operating under
31 Chapter 884;

32 (5) a reciprocal exchange operating under Chapter 942;

33 (6) a health maintenance organization operating under
34 Chapter 843;

35 (7) a multiple employer welfare arrangement that holds
36 a certificate of authority under Chapter 846; or

37 (8) an approved nonprofit health corporation that
38 holds a certificate of authority under Chapter 844. (V.T.I.C.

1 Art. 21.52L, Secs. 2(a), (b), as added Acts 77th Leg., R.S., Ch.
2 1106.)

3 Source Law

4 Sec. 2. (a) In this article, "health benefit
5 plan" means a plan that provides benefits for medical
6 or surgical expenses incurred as a result of a health
7 condition, accident, or sickness, including an
8 individual, group, blanket, or franchise insurance
9 policy or insurance agreement, a group hospital
10 service contract, or an individual or group evidence
11 of coverage or similar coverage document that is
12 offered by:

- 13 (1) an insurance company;
14 (2) a group hospital service corporation
15 operating under Chapter 20 of this code;
16 (3) a fraternal benefit society operating
17 under Chapter 10 of this code;
18 (4) a stipulated premium insurance company
19 operating under Chapter 22 of this code;
20 (5) a reciprocal exchange operating under
21 Chapter 19 of this code;
22 (6) a health maintenance organization
23 operating under the Texas Health Maintenance
24 Organization Act (Chapter 20A, Vernon's Texas
25 Insurance Code);
26 (7) a multiple employer welfare
27 arrangement that holds a certificate of authority
28 under Article 3.95-2 of this code; or
29 (8) an approved nonprofit health
30 corporation that holds a certificate of authority
31 under Article 21.52F of this code.
32 (b) "Health benefit plan" includes a small
33 employer health benefit plan offered in accordance
34 with Chapter 26 of this code.

35 Revised Law

36 Sec. 1369.103. EXCEPTION. This subchapter does not apply
37 to:

- 38 (1) a health benefit plan that provides coverage only:
39 (A) for a specified disease or for another
40 limited benefit other than for cancer;
41 (B) for accidental death or dismemberment;
42 (C) for wages or payments in lieu of wages for a
43 period during which an employee is absent from work because of
44 sickness or injury;
45 (D) as a supplement to a liability insurance
46 policy;
47 (E) for credit insurance;
48 (F) for dental or vision care; or
49 (G) for indemnity for hospital confinement;

1 (2) a Medicare supplemental policy as defined by
2 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),
3 as amended;

4 (3) a workers' compensation insurance policy;

5 (4) medical payment insurance coverage provided under
6 a motor vehicle insurance policy; or

7 (5) a long-term care insurance policy, including a
8 nursing home fixed indemnity policy, unless the commissioner
9 determines that the policy provides benefit coverage so
10 comprehensive that the policy is a health benefit plan as described
11 by Section 1369.102. (V.T.I.C. Art. 21.52L, Sec. 2(c), as added
12 Acts 77th Leg., R.S., Ch. 1106.)

13 Source Law

14 (c) "Health benefit plan" does not include:

15 (1) a plan that provides coverage only:

16 (A) for benefits for a specified
17 disease or for another limited benefit other than for
18 cancer;

19 (B) for accidental death or
20 dismemberment;

21 (C) for wages or payments in lieu of
22 wages for a period during which an employee is absent
23 from work because of sickness or injury;

24 (D) as a supplement to a liability
25 insurance policy;

26 (E) for credit insurance;

27 (F) for dental or vision care; or

28 (G) for indemnity for hospital
29 confinement;

30 (2) a Medicare supplemental policy as
31 defined by Section 1882(g)(1), Social Security Act (42
32 U.S.C. Section 1395ss), as amended;

33 (3) a workers' compensation insurance
34 policy;

35 (4) medical payment insurance coverage
36 provided under a motor vehicle insurance policy; or

37 (5) a long-term care insurance policy,
38 including a nursing home fixed indemnity policy,
39 unless the commissioner determines that the policy
40 provides benefit coverage so comprehensive that the
41 policy is a health benefit plan as described by
42 Subsection (a) of this section.

43 Revised Law

44 Sec. 1369.104. EXCLUSION OR LIMITATION PROHIBITED. (a) A
45 health benefit plan that provides benefits for prescription drugs
46 or devices may not exclude or limit benefits to enrollees for:

47 (1) a prescription contraceptive drug or device
48 approved by the United States Food and Drug Administration; or

1 (2) an outpatient contraceptive service.

2 (b) This section does not prohibit a limitation that applies
3 to all prescription drugs or devices or all services for which
4 benefits are provided under a health benefit plan.

5 (c) This section does not require a health benefit plan to
6 cover abortifacients or any other drug or device that terminates a
7 pregnancy. (V.T.I.C. Art. 21.52L, Sec. 3, as added Acts 77th Leg.,
8 R.S., Ch. 1106.)

9 Source Law

10 Sec. 3. (a) A health benefit plan that
11 provides benefits for prescription drugs or devices
12 may not exclude or limit benefits to enrollees for:

13 (1) a prescription contraceptive drug or
14 device approved by the United States Food and Drug
15 Administration; or

16 (2) an outpatient contraceptive service.

17 (b) This section does not prohibit a limitation
18 that applies to all prescription drugs or devices or
19 all services for which benefits are provided under a
20 health benefit plan.

21 (c) This section does not provide coverage for
22 abortifacients or any other drug or device that
23 terminates a pregnancy.

24 Revised Law

25 Sec. 1369.105. CERTAIN COST-SHARING PROVISIONS PROHIBITED.

26 (a) A health benefit plan may not impose a deductible, copayment,
27 coinsurance, or other cost-sharing provision applicable to
28 benefits for prescription contraceptive drugs or devices unless the
29 amount of the required cost-sharing is the same as or less than the
30 amount of the required cost-sharing applicable to benefits for
31 other prescription drugs or devices under the plan.

32 (b) A health benefit plan may not impose a deductible,
33 copayment, coinsurance, or other cost-sharing provision applicable
34 to benefits for outpatient contraceptive services unless the amount
35 of the required cost-sharing is the same as or less than the amount
36 of the required cost-sharing applicable to benefits for other
37 outpatient services under the plan. (V.T.I.C. Art. 21.52L, Sec. 4,
38 as added Acts 77th Leg., R.S., Ch. 1106.)

39 Source Law

40 Sec. 4. (a) A health benefit plan may not
41 impose any deductible, copayment, coinsurance, or

1 other cost-sharing provision applicable to benefits
2 for prescription contraceptive drugs or devices unless
3 the amount of the required cost-sharing does not
4 exceed the amount of the required cost-sharing
5 applicable to benefits for other prescription drugs or
6 devices under the plan.

7 (b) A health benefit plan may not impose any
8 deductible, copayment, coinsurance, or other
9 cost-sharing provision applicable to benefits for
10 outpatient contraceptive services unless the amount of
11 the required cost-sharing does not exceed the amount
12 of the required cost-sharing applicable to benefits
13 for other outpatient services under the plan.

14 Revised Law

15 Sec. 1369.106. CERTAIN WAITING PERIODS PROHIBITED. (a) A
16 health benefit plan may not impose a waiting period applicable to
17 benefits for prescription contraceptive drugs or devices unless the
18 waiting period is the same as or shorter than any waiting period
19 applicable to benefits for other prescription drugs or devices
20 under the plan.

21 (b) A health benefit plan may not impose a waiting period
22 applicable to benefits for outpatient contraceptive services
23 unless the waiting period is the same as or shorter than any waiting
24 period applicable to benefits for other outpatient services under
25 the plan. (V.T.I.C. Art. 21.52L, Sec. 5, as added Acts 77th Leg.,
26 R.S., Ch. 1106.)

27 Source Law

28 Sec. 5. (a) A health benefit plan may not
29 impose any waiting period applicable to benefits for
30 prescription contraceptive drugs or devices unless the
31 waiting period is not longer than any waiting period
32 applicable to benefits for other prescription drugs or
33 devices under the plan.

34 (b) A health benefit plan may not impose any
35 waiting period applicable to benefits for outpatient
36 contraceptive services unless the waiting period is
37 not longer than any waiting period applicable to
38 benefits for other outpatient services under the plan.

39 Revised Law

40 Sec. 1369.107. PROHIBITED CONDUCT. A health benefit plan
41 issuer may not:

42 (1) solely because of the applicant's or enrollee's
43 use or potential use of a prescription contraceptive drug or device
44 or an outpatient contraceptive service, deny:

45 (A) the eligibility of an applicant to enroll in

1 the plan;

2 (B) the continued eligibility of an enrollee for
3 coverage under the plan; or

4 (C) the eligibility of an enrollee to renew
5 coverage under the plan;

6 (2) provide a monetary incentive to an applicant for
7 enrollment or an enrollee to induce the applicant or enrollee to
8 accept coverage that does not satisfy the requirements of this
9 subchapter; or

10 (3) reduce or limit a payment to a health care
11 professional, or otherwise penalize the professional, because the
12 professional prescribes a contraceptive drug or device or provides
13 an outpatient contraceptive service. (V.T.I.C. Art. 21.52L, Sec.
14 6, as added Acts 77th Leg., R.S., Ch. 1106.)

15 Source Law

16 Sec. 6. The issuer of a health benefit plan may
17 not:

18 (1) deny an applicant for enrollment or an
19 enrollee eligibility or continued eligibility under
20 the plan, or deny renewal of a plan to an enrollee,
21 solely because of the applicant's or enrollee's use or
22 potential use of a prescription contraceptive drug or
23 device or an outpatient contraceptive service;

24 (2) provide a monetary incentive to an
25 applicant for enrollment or an enrollee to induce the
26 applicant or enrollee to accept coverage that does not
27 satisfy the requirements of this article; or

28 (3) reduce or limit a payment to a health
29 care professional, or otherwise penalize the
30 professional, because the professional prescribes a
31 contraceptive drug or device or provides an
32 outpatient contraceptive service.

33 Revised Law

34 Sec. 1369.108. EXEMPTION FOR ENTITIES ASSOCIATED WITH
35 RELIGIOUS ORGANIZATION. (a) This subchapter does not require a
36 health benefit plan that is issued by an entity associated with a
37 religious organization or any physician or health care provider
38 providing medical or health care services under the plan to offer,
39 recommend, offer advice concerning, pay for, provide, assist in,
40 perform, arrange, or participate in providing or performing a
41 medical or health care service that violates the religious
42 convictions of the organization, unless the prescription

1 contraceptive coverage is necessary to preserve the life or health
2 of the enrollee.

3 (b) An issuer of a health benefit plan that excludes or
4 limits coverage for medical or health care services under this
5 section shall state the exclusion or limitation in:

- 6 (1) the plan's coverage document;
- 7 (2) the plan's statement of benefits;
- 8 (3) plan brochures; and
- 9 (4) other informational materials for the plan.

10 (V.T.I.C. Art. 21.52L, Sec. 7, as added Acts 77th Leg., R.S., Ch.
11 1106.)

12 Source Law

13 Sec. 7. (a) This article does not require a
14 health benefit plan that is issued by an entity
15 associated with a religious organization or any
16 physician or health care provider providing medical or
17 health care services under the health benefit plan to
18 offer, recommend, offer advice concerning, pay for,
19 provide, assist in, perform, arrange, or participate
20 in providing or performing a medical or health care
21 service that violates the religious convictions of the
22 organization, except if the prescription
23 contraceptive coverage is necessary to preserve the
24 life or health of the insured individual.

25 (b) The issuer of a health benefit plan that
26 limits or excludes coverage for medical or health care
27 services under this section must state the limitation
28 or exclusion in the coverage document, the plan's
29 statement of benefits, brochures, and other
30 informational materials for the health benefit plan.

31 Revisor's Note

32 Section 7(a), V.T.I.C. Article 21.52L, as added
33 by Chapter 1106, Acts of the 77th Legislature, Regular
34 Session, 2001, refers to an "insured individual."
35 "Insured" is a term used in conjunction with
36 traditional insurance. This subchapter applies to
37 health benefit plans offered by entities such as
38 health maintenance organizations that are not
39 insurers. Consequently, "enrollee" is a more accurate
40 term than "insured individual." In addition,
41 "enrollee" is the defined term used in the subchapter.
42 Thus, the revised law substitutes "enrollee" for

1 "insured individual."

2 Revised Law

3 Sec. 1369.109. ENFORCEMENT. A health benefit plan issuer
4 that violates this subchapter is subject to the enforcement
5 provisions of Subtitle B, Title 2. (V.T.I.C. Art. 21.52L, Sec. 8,
6 as added Acts 77th Leg., R.S., Ch. 1106.)

7 Source Law

8 Sec. 8. The issuer of a health benefit plan that
9 violates this article is subject to the enforcement
10 provisions of Subtitle B, Title 2, of this code.

11 [Sections 1369.110-1369.150 reserved for expansion]

12 SUBCHAPTER D. PHARMACY BENEFIT CARDS

13 Revised Law

14 Sec. 1369.151. APPLICABILITY OF SUBCHAPTER. This
15 subchapter applies only to a health benefit plan that provides
16 benefits for medical or surgical expenses incurred as a result of a
17 health condition, accident, or sickness, including an individual,
18 group, blanket, or franchise insurance policy or insurance
19 agreement, a group hospital service contract, or an individual or
20 group evidence of coverage or similar coverage document that is
21 offered by:

22 (1) an insurance company;

23 (2) a group hospital service corporation operating
24 under Chapter 842;

25 (3) a fraternal benefit society operating under
26 Chapter 885;

27 (4) a stipulated premium company operating under
28 Chapter 884;

29 (5) a reciprocal exchange operating under Chapter 942;

30 (6) a health maintenance organization operating under
31 Chapter 843;

32 (7) a multiple employer welfare arrangement that holds
33 a certificate of authority under Chapter 846; or

34 (8) an approved nonprofit health corporation that
35 holds a certificate of authority under Chapter 844. (V.T.I.C.

1 Art. 21.53L, Sec. 2(a).)

2 Source Law

3 Sec. 2. (a) This article applies only to a
4 health benefit plan that provides benefits for medical
5 or surgical expenses incurred as a result of a health
6 condition, accident, or sickness, including an
7 individual, group, blanket, or franchise insurance
8 policy or insurance agreement, a group hospital
9 service contract, or an individual or group evidence
10 of coverage or similar coverage document that is
11 offered by:

- 12 (1) an insurance company;
13 (2) a group hospital service corporation
14 operating under Chapter 20 of this code;
15 (3) a fraternal benefit society operating
16 under Chapter 10 of this code;
17 (4) a stipulated premium insurance company
18 operating under Chapter 22 of this code;
19 (5) a reciprocal exchange operating under
20 Chapter 19 of this code;
21 (6) a health maintenance organization
22 operating under the Texas Health Maintenance
23 Organization Act (Chapter 20A, Vernon's Texas
24 Insurance Code);
25 (7) a multiple employer welfare
26 arrangement that holds a certificate of authority
27 under Article 3.95-2 of this code; or
28 (8) an approved nonprofit health
29 corporation that holds a certificate of authority
30 issued by the commissioner under Article 21.52F of
31 this code.

32 Revisor's Note

33 Section 2(a)(8), V.T.I.C. Article 21.53L, refers
34 to an approved nonprofit health corporation that holds
35 a certificate of authority "issued by the
36 commissioner." The revised law omits the quoted
37 language for the reason stated in the revisor's note to
38 Section 1369.002.

39 Revised Law

40 Sec. 1369.152. EXCEPTION. This subchapter does not apply
41 to:

- 42 (1) a health benefit plan that provides coverage:
43 (A) only for a specified disease or for another
44 limited benefit;
45 (B) only for accidental death or dismemberment;
46 (C) for wages or payments in lieu of wages for a
47 period during which an employee is absent from work because of
48 sickness or injury;

1 (D) as a supplement to a liability insurance
2 policy;

3 (E) for credit insurance;

4 (F) only for dental or vision care;

5 (G) only for hospital expenses; or

6 (H) only for indemnity for hospital confinement;

7 (2) a small employer health benefit plan written under
8 Chapter 1501;

9 (3) a Medicare supplemental policy as defined by
10 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

11 (4) a workers' compensation insurance policy;

12 (5) medical payment insurance coverage provided under
13 a motor vehicle insurance policy; or

14 (6) a long-term care insurance policy, including a
15 nursing home fixed indemnity policy, unless the commissioner
16 determines that the policy provides benefit coverage so
17 comprehensive that the policy is a health benefit plan as described
18 by Section 1369.151. (V.T.I.C. Art. 21.53L, Sec. 2(b).)

19 Source Law

20 (b) This article does not apply to:

21 (1) a plan that provides coverage:

22 (A) only for a specified disease or
23 other limited benefit;

24 (B) only for accidental death or
25 dismemberment;

26 (C) for wages or payments in lieu of
27 wages for a period during which an employee is absent
28 from work because of sickness or injury;

29 (D) as a supplement to liability
30 insurance;

31 (E) for credit insurance;

32 (F) only for dental or vision care;

33 (G) only for hospital expenses; or

34 (H) only for indemnity for hospital
35 confinement;

36 (2) a small employer health benefit plan
37 written under Chapter 26 of this code;

38 (3) a Medicare supplemental policy as
39 defined by Section 1882(g)(1), Social Security Act (42
40 U.S.C. Section 1395ss);

41 (4) workers' compensation insurance
42 coverage;

43 (5) medical payment insurance coverage
44 issued as part of a motor vehicle insurance policy; or

45 (6) a long-term care policy, including a
46 nursing home fixed indemnity policy, unless the
47 commissioner determines that the policy provides
48 benefit coverage so comprehensive that the policy is a

1 health benefit plan as described by Subsection (a) of
2 this section.

3 Revised Law

4 Sec. 1369.153. INFORMATION REQUIRED ON IDENTIFICATION
5 CARD. (a) An issuer of a health benefit plan that provides
6 pharmacy benefits to enrollees shall include on the identification
7 card of each enrollee:

8 (1) the name or logo of the entity administering the
9 pharmacy benefits if the entity is different from the health
10 benefit plan issuer;

11 (2) the group number applicable to the enrollee;

12 (3) the effective date of the coverage evidenced by
13 the card;

14 (4) a telephone number for contacting an appropriate
15 person to obtain information relating to the pharmacy benefits
16 provided under the plan; and

17 (5) copayment information for generic and brand-name
18 prescription drugs.

19 (b) This section does not require a health benefit plan
20 issuer that administers its own pharmacy benefits to issue an
21 identification card separate from any identification card issued to
22 an enrollee to evidence coverage under the plan if the
23 identification card issued to evidence coverage contains the
24 information required by Subsection (a). (V.T.I.C. Art. 21.53L,
25 Sec. 3.)

26 Source Law

27 Sec. 3. (a) A health benefit plan that
28 provides pharmacy benefits for enrollees in the plan
29 shall include on the identification card of each
30 enrollee:

31 (1) the name or logo of the entity that is
32 administering the pharmacy benefits, if different from
33 the health benefit plan;

34 (2) the group number applicable to the
35 individual;

36 (3) the effective date of the coverage
37 evidenced by the card;

38 (4) a telephone number to be used to
39 contact an appropriate person to obtain information
40 relating to the pharmacy benefits provided under the
41 coverage; and

42 (5) copayment information for generic and
43 brand-name prescription drugs.

1 (b) This section does not require a health
2 benefit plan that administers its own pharmacy
3 benefits to issue an identification card separate from
4 any identification card issued to an enrollee to
5 evidence coverage under the health benefit plan, if
6 the identification card contains the elements required
7 by Subsection (a) of this section.

8 Revised Law

9 Sec. 1369.154. RULES. The commissioner shall adopt rules
10 as necessary to implement this subchapter. (V.T.I.C. Art. 21.53L,
11 Sec. 4.)

12 Source Law

13 Sec. 4. The commissioner shall adopt rules as
14 necessary to implement this article.

15 Revisor's Note
16 (End of Subchapter)

17 Section 1, V.T.I.C. Article 21.53L, defines
18 "health benefit plan." The revised law omits the
19 definition as unnecessary because Section 2 of that
20 article, revised as Sections 1369.151 and 1369.152,
21 specifies the types of health benefit plans to which
22 this subchapter applies, and thus the defined term is
23 not helpful to the reader. The omitted law reads:

24 Art. 21.53L
25 Sec. 1. In this article, "health
26 benefit plan" means a health benefit plan
27 described by Section 2 of this article.

28 [Chapters 1370-1450 reserved for expansion]

29 SUBTITLE F. PHYSICIANS AND HEALTH CARE PROVIDERS

30 CHAPTER 1451. ACCESS TO CERTAIN PRACTITIONERS AND FACILITIES

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21 CHAPTER 1451. ACCESS TO CERTAIN PRACTITIONERS AND FACILITIES

22 SUBCHAPTER A. GENERAL PROVISIONS

23 Revised Law

24 Sec. 1451.001. DEFINITIONS; HEALTH CARE PRACTITIONERS. In

25 this chapter:

26 (1) "Acupuncturist" means an individual licensed to

27 practice acupuncture by the Texas State Board of Medical Examiners.

28 (2) "Advanced practice nurse" means an individual

29 licensed by the Board of Nurse Examiners as a registered nurse and

30 recognized by that board as an advanced practice nurse.

31 (3) "Audiologist" means an individual licensed to

32 practice audiology by the State Board of Examiners for

33 Speech-Language Pathology and Audiology.

34 (4) "Chemical dependency counselor" means an

1 individual licensed by the Texas Commission on Alcohol and Drug
2 Abuse.

3 (5) "Chiropractor" means an individual licensed by the
4 Texas Board of Chiropractic Examiners.

5 (6) "Dentist" means an individual licensed to practice
6 dentistry by the State Board of Dental Examiners.

7 (7) "Dietitian" means an individual licensed by the
8 Texas State Board of Examiners of Dietitians.

9 (8) "Hearing instrument fitter and dispenser" means an
10 individual licensed by the State Committee of Examiners in the
11 Fitting and Dispensing of Hearing Instruments.

12 (9) "Licensed master social worker--advanced clinical
13 practitioner" means an individual licensed by the Texas State Board
14 of Social Worker Examiners as a licensed master social worker with
15 the order of recognition of advanced clinical practitioner.

16 (10) "Licensed professional counselor" means an
17 individual licensed by the Texas State Board of Examiners of
18 Professional Counselors.

19 (11) "Marriage and family therapist" means an
20 individual licensed by the Texas State Board of Examiners of
21 Marriage and Family Therapists.

22 (12) "Occupational therapist" means an individual
23 licensed as an occupational therapist by the Texas Board of
24 Occupational Therapy Examiners.

25 (13) "Optometrist" means an individual licensed to
26 practice optometry by the Texas Optometry Board.

27 (14) "Physical therapist" means an individual
28 licensed as a physical therapist by the Texas Board of Physical
29 Therapy Examiners.

30 (15) "Physician" means an individual licensed to
31 practice medicine by the Texas State Board of Medical Examiners.
32 The term includes a doctor of osteopathic medicine.

33 (16) "Physician assistant" means an individual
34 licensed by the Texas State Board of Physician Assistant Examiners.

1 (17) "Podiatrist" means an individual licensed to
2 practice podiatry by the Texas State Board of Podiatric Medical
3 Examiners.

4 (18) "Psychological associate" means an individual
5 licensed as a psychological associate by the Texas State Board of
6 Examiners of Psychologists who practices solely under the
7 supervision of a licensed psychologist.

8 (19) "Psychologist" means an individual licensed as a
9 psychologist by the Texas State Board of Examiners of
10 Psychologists.

11 (20) "Speech-language pathologist" means an
12 individual licensed to practice speech-language pathology by the
13 State Board of Examiners for Speech-Language Pathology and
14 Audiology.

15 (21) "Surgical assistant" means an individual
16 licensed as a surgical assistant by the Texas State Board of Medical
17 Examiners. (V.T.I.C. Art. 3.70-2, Sec. (B) (part); Art. 21.52,
18 Sec. 1 (part), as amended Acts 77th Leg., R.S., Ch. 1014.)

19 Source Law

20 [Art. 3.70-2]

21 (B) . . .

22 For purposes of this Act, such designations shall
23 have the following meanings:

24 Doctor of Medicine: One licensed by the Texas
25 State Board of Medical Examiners on the basis of the
26 degree "Doctor of Medicine";

27 Doctor of Osteopathy: One licensed by the Texas
28 State Board of Medical Examiners on the basis of the
29 degree of "Doctor of Osteopathy";

30 Doctor of Dentistry: One licensed by the State
31 Board of Dental Examiners;

32 Doctor of Chiropractic: One licensed by the
33 Texas Board of Chiropractic Examiners;

34 Doctor of Optometry: One licensed by the Texas
35 Optometry Board;

36 Doctor of Podiatry: One licensed by the Texas
37 State Board of Podiatric Medical Examiners;

38 Licensed Audiologist: One with a master's or
39 doctorate degree in audiology from an accredited
40 college or university and who is licensed as an
41 audiologist by the State Board of Examiners for
42 Speech-Language Pathology and Audiology;

43 Licensed Speech-language Pathologist: One with a
44 master's or doctorate degree in speech pathology or
45 speech-language pathology from an accredited college
46 or university and who is licensed as a speech-language
47 pathologist by the State Board of Examiners for
48 Speech-Language Pathology and Audiology;

1 Doctor in Psychology: One licensed by the Texas
2 State Board of Examiners of Psychologists and
3 certified as a Health Service Provider;

4 Licensed Master Social Worker--Advanced Clinical
5 Practitioner: One licensed by the Texas State Board of
6 Social Worker Examiners as a Licensed Master Social
7 Worker with the order of recognition of Advanced
8 Clinical Practitioner;

9 Licensed Dietitian: One licensed by the Texas
10 State Board of Examiners of Dietitians;

11 Licensed Professional Counselor: One licensed by
12 the Texas State Board of Examiners of Professional
13 Counselors;

14 Licensed Marriage and Family Therapist: One
15 licensed by the Texas State Board of Examiners of
16 Marriage and Family Therapists;

17 Licensed Chemical Dependency Counselor: One
18 licensed by the Texas Commission on Alcohol and Drug
19 Abuse;

20 Licensed Hearing Instrument Fitter and
21 Dispenser: One licensed by the State Committee of
22 Examiners in the Fitting and Dispensing of Hearing
23 Instruments;

24 Advanced Practice Nurse: One licensed by the
25 Board of Nurse Examiners as a registered nurse and
26 recognized by that board as an advanced practice
27 nurse;

28 Physician Assistant: One licensed by the Texas
29 State Board of Physician Assistant Examiners;

30 Licensed Occupational Therapist: One licensed by
31 the Texas Board of Occupational Therapy Examiners;

32 Licensed Physical Therapist: One licensed by the
33 Texas Board of Physical Therapy Examiners;

34 Licensed Acupuncturist: One licensed by the
35 Texas State Board of Medical Examiners as an
36 acupuncturist;

37 Licensed Psychological Associate: One licensed
38 by the Texas State Board of Examiners of Psychologists
39 and practicing under the supervision of a licensed
40 psychologist; and

41 Licensed Surgical Assistant: One licensed by the
42 Texas State Board of Medical Examiners as a surgical
43 assistant.

44 Art. 21.52

45 Sec. 1. As used in this article:

46 . . .
47 (b) "doctor of podiatric medicine"
48 includes D.P.M., podiatrist, doctor of surgical
49 chiropody, D.S.C. and chiropodist;

50 (c) "doctor of optometry" includes
51 optometrist, doctor of optometry, and O.D.;

52 (d) "doctor of chiropractic" means a
53 person who is licensed by the Texas Board of
54 Chiropractic Examiners to practice chiropractic;

55 (e) "licensed dentist" means a person who
56 is licensed to practice dentistry by the State Board of
57 Dental Examiners;

58 (f) "licensed audiologist" means a person
59 who has received a master's or doctorate degree in
60 audiology from an accredited college or university and
61 is licensed as an audiologist by the State Board of
62 Examiners for Speech-Language Pathology and
63 Audiology;

64 (g) "licensed speech-language
65 pathologist" means a person who has received a master's
66 or doctorate degree in speech-language pathology from
67 an accredited college or university and is licensed as

1 a speech-language pathologist by the State Board of
2 Examiners for Speech-Language Pathology and
3 Audiology;

4 (h) "licensed master social
5 worker--advanced clinical practitioner" means a
6 person who is licensed by the Texas State Board of
7 Social Worker Examiners as a licensed master social
8 worker with the order of recognition of advanced
9 clinical practitioner;

10 (i) "licensed dietitian" means a person
11 who is licensed by the Texas State Board of Examiners
12 of Dietitians;

13 (j) "licensed professional counselor"
14 means a person who is licensed by the Texas State Board
15 of Examiners of Professional Counselors;

16 (k) "psychologist" means a person licensed
17 to practice psychology by the Texas State Board of
18 Examiners of Psychologists;

19 (l) "licensed marriage and family
20 therapist" means a person who is licensed by the Texas
21 State Board of Examiners of Marriage and Family
22 Therapists;

23 (m) "licensed chemical dependency
24 counselor" means a person who is licensed by the Texas
25 Commission on Alcohol and Drug Abuse;

26 (n) "licensed hearing instrument fitter
27 and dispenser" means a person who is licensed by the
28 State Committee of Examiners in the Fitting and
29 Dispensing of Hearing Instruments;

30 (o) "licensed psychological associate"
31 means a person who is licensed by the Texas State Board
32 of Examiners of Psychologists and who practices under
33 the supervision of a licensed psychologist;

34 (p) "occupational therapist" means a
35 person who is licensed to practice occupational
36 therapy by the Texas Board of Occupational Therapy
37 Examiners;

38 (q) "physical therapist" means a person
39 who practices physical therapy and is licensed by the
40 Texas Board of Physical Therapy Examiners;

41 (r) "advanced practice nurse" means a
42 person licensed by the Board of Nurse Examiners and
43 recognized by that board as an advanced practice
44 nurse;

45 (s) "licensed acupuncturist" means a
46 person licensed to practice acupuncture by the Texas
47 State Board of Medical Examiners;

48 (t) "physician assistant" means a person
49 licensed by the Texas State Board of Physician
50 Assistant Examiners; and

51 (u) "Surgical assistant" means a person
52 licensed by the Texas State Board of Medical Examiners
53 as a surgical assistant.

54 Revisor's Note

55 (1) Section (B), V.T.I.C. Article 3.70-2, and
56 Section 1, V.T.I.C. Article 21.52, each contain a list
57 of regulated health care practitioners who may be
58 designated under certain health benefit plans to
59 provide services to covered individuals. In general,
60 the lists are substantively very similar. Article

1 3.70-2, originally enacted in 1955, uses older
2 terminology than the designations used in Article
3 21.52, which was enacted in 1977. In addition, the
4 list in Article 21.52 includes "nurse first assistant"
5 which is not included in the list in Article 3.70-2.
6 In 1999, the 76th Legislature originally enacted Title
7 3 of the Occupations Code, which contains the
8 licensing acts for each of the health care professions
9 listed in Articles 3.70-2 and 21.52. To avoid
10 redundancy and to conform to the latest statement of
11 legislative intent regarding the regulated
12 professions as evidenced by the Occupations Code, the
13 revised law merges the two lists, other than "nurse
14 first assistant," which is revised in Subchapter C
15 with the remaining provisions of Article 21.52, and
16 conforms the designations used throughout this chapter
17 to the terms used for those professions in the
18 Occupations Code.

19 (2) Section (B), V.T.I.C. Article 3.70-2,
20 refers to a "doctor of medicine" and a "doctor of
21 osteopathy." Under Subtitle B, Title 3, Occupations
22 Code, both doctors of medicine and doctors of
23 osteopathy are regulated by the Texas State Board of
24 Medical Examiners and are issued licenses to practice
25 medicine. Section 151.002, Occupations Code, defines
26 "physician" as "a person licensed to practice medicine
27 in this state." The revised law therefore substitutes
28 "physician" for "doctor of medicine" and "doctor of
29 osteopathy" throughout this chapter and adds an
30 express reference in the definition to an osteopathic
31 physician.

32 (3) Section (B), V.T.I.C. Article 3.70-2,
33 refers to a "doctor of dentistry" as "[o]ne licensed by
34 the State Board of Dental Examiners." Under Subtitle

1 D, Title 3, Occupations Code, the State Board of Dental
2 Examiners licenses both dentists and dental
3 hygienists. The revised law substitutes the term
4 "dentist" for clarification.

5 (4) Section (B), V.T.I.C. Article 3.70-2, and
6 Sections 1(f) and (g), V.T.I.C. Article 21.52, refer
7 to a "licensed audiologist" and a "licensed
8 speech-language pathologist" and specify certain
9 educational requirements for those licenses. Under
10 Chapter 401, Occupations Code, both audiologists and
11 speech-language pathologists are regulated by the
12 State Board of Examiners for Speech-Language Pathology
13 and Audiology. Under Section 401.304, Occupations
14 Code, to be eligible for a license as an audiologist or
15 a speech-language pathologist, an applicant must
16 comply with educational requirements that are
17 substantially identical to those required under
18 Articles 3.70-2 and 21.52. It is unnecessary to repeat
19 those requirements in the revised law.

20 (5) Section (B), V.T.I.C. Article 3.70-2,
21 refers to a "doctor in psychology" as a person licensed
22 by the Texas State Board of Examiners of Psychologists
23 "and certified as a Health Service Provider." The
24 revised law omits the reference to certification as a
25 health service provider because such a certification
26 does not exist under Chapter 501, Occupations Code,
27 the licensing statute for psychologists, or under the
28 rules adopted to implement that chapter.

29 (6) Section (B), V.T.I.C. Article 3.70-2,
30 refers to a "licensed physical therapist" as "[o]ne
31 licensed by the Texas Board of Physical Therapy
32 Examiners." Under Chapter 453, Occupations Code, that
33 board licenses both physical therapists and physical
34 therapist assistants. For clarification, the revised

1 law specifies that a physical therapist is a person
2 licensed "as a physical therapist."

3 (7) Section (B), V.T.I.C. Article 3.70-2,
4 refers to a "licensed occupational therapist" as
5 "[o]ne licensed by the Texas Board of Occupational
6 Therapy Examiners." Under Chapter 454, Occupations
7 Code, that board licenses both occupational therapists
8 and occupational therapy assistants. For
9 clarification, the revised law specifies that an
10 occupational therapist is a person licensed "as an
11 occupational therapist."

12 [Sections 1451.002-1451.050 reserved for expansion]

13 SUBCHAPTER B. DESIGNATION OF PRACTITIONERS UNDER
14 ACCIDENT AND HEALTH INSURANCE POLICY

15 Revised Law

16 Sec. 1451.051. APPLICABILITY OF SUBCHAPTER. (a) This
17 subchapter applies to an accident and health insurance policy,
18 including an individual, blanket, or group policy.

19 (b) This subchapter applies to an accident and health
20 insurance policy issued by a stipulated premium company subject to
21 Chapter 884. (V.T.I.C. Art. 3.70-8, Secs. (a) (part), (b).)

22 Source Law

23 Art. 3.70-8. (a) [Nothing in this Act shall
24 apply to . . . any blanket or group policy of
25 insurance except as provided in Subsections] (B)
26 and . . . [of Section 2]

27 (b) This Act applies to a health, accident,
28 sickness, and hospitalization policy issued by a
29 stipulated premium insurer subject to Chapter 884 of
30 this code.

31 Revisor's Note

32 Sections (a) and (b), V.T.I.C. Article 3.70-8,
33 refer to a "blanket or group policy of insurance,"
34 meaning a policy of accident and sickness insurance
35 described by Section (B), V.T.I.C. Article 3.70-2, and
36 to a "health, accident, sickness, and hospitalization
37 policy," respectively. The revised law substitutes

1 the phrase "accident and health insurance" throughout
2 this subchapter as appropriate for consistency with
3 modern usage and the terminology used in Chapter 1201
4 of this code.

5 Revised Law

6 Sec. 1451.052. APPLICABILITY OF GENERAL PROVISIONS OF OTHER
7 LAW. The provisions of Chapter 1201, including provisions
8 relating to the applicability, purpose, and enforcement of that
9 chapter, the construction of policies under that chapter,
10 rulemaking under that chapter, and definitions of terms applicable
11 in that chapter, apply to this subchapter. (New.)

12 Revisor's Note

13 Chapter 397, Acts of the 54th Legislature,
14 Regular Session, 1955, published as V.T.I.C. Articles
15 3.70-1, 3.70-2, 3.70-3, 3.70-3A, 3.70-3B, 3.70-4,
16 3.70-5, 3.70-6, 3.70-7, 3.70-8, 3.70-9, 3.70-10, and
17 3.70-11, contains general provisions applicable to
18 Section (B), V.T.I.C. Article 3.70-2, revised as this
19 subchapter. The majority of those articles are
20 revised in this code as Chapter 1201. Section 1451.052
21 is added to indicate the applicability of those
22 general provisions to this subchapter. For the
23 convenience of the reader, the revised law includes
24 general descriptions of some of the applicable
25 provisions of Chapter 1201.

26 Revised Law

27 Sec. 1451.053. PRACTITIONER DESIGNATION. (a) An accident
28 and health insurance policy may not make a benefit contingent on
29 treatment or examination by one or more particular health care
30 practitioners listed in Section 1451.001 unless the policy contains
31 a provision that designates the practitioners whom the insurer will
32 and will not recognize.

33 (b) The insurer may include the provision anywhere in the
34 policy or in an endorsement attached to the policy. (V.T.I.C.

1 Art. 3.70-2, Sec. (B) (part).)

2 Source Law

3 (B) No policy of accident and sickness insurance
4 shall make benefits contingent upon treatment or
5 examination by a particular practitioner or by
6 particular practitioners of the healing arts
7 hereinafter designated unless such policy contains a
8 provision designating the practitioner or
9 practitioners who will be recognized by the insurer
10 and those who will not be recognized by the insurer.
11 Such provision may be located in the "Exceptions" or
12 "Exceptions and Reductions" provisions, or elsewhere
13 in the policy, or by endorsement attached to the
14 policy, at the insurer's option. . . .

15 Revisor's Note

16 Section (B), V.T.I.C. Article 3.70-2, provides
17 that "at the insurer's option" a provision that
18 designates providers "may be located in the
19 "Exceptions" or "Exceptions and Reductions"
20 provisions, or elsewhere in the policy." The revised
21 law omits as unnecessary the reference to the
22 "Exceptions" or "Exceptions and Reductions"
23 provisions. Because the insurer may locate the
24 provision anywhere in the policy, a reference to an
25 example of such a location is superfluous.

26 Revised Law

27 Sec. 1451.054. TERMS USED TO DESIGNATE HEALTH CARE
28 PRACTITIONERS. A provision of an accident and health insurance
29 policy that designates the health care practitioners whom the
30 insurer will and will not recognize must use the terms defined by
31 Section 1451.001 with the meanings assigned by that section.
32 (V.T.I.C. Art. 3.70-2, Sec. (B) (part).)

33 Source Law

34 (B) . . . In designating the practitioners who
35 will and will not be recognized, such provision shall
36 use the following terms: Doctor of Medicine, Doctor of
37 Osteopathy, Doctor of Dentistry, Doctor of
38 Chiropractic, Doctor of Optometry, Doctor of Podiatry,
39 Licensed Audiologist, Licensed Speech-language
40 Pathologist, Doctor in Psychology, Licensed Master
41 Social Worker--Advanced Clinical Practitioner,
42 Licensed Dietitian, Licensed Professional Counselor,
43 Licensed Marriage and Family Therapist, Licensed
44 Chemical Dependency Counselor, Licensed Hearing
45 Instrument Fitter and Dispenser, Advanced Practice

1 Nurse, Physician Assistant, Licensed Occupational
2 Therapist, Licensed Physical Therapist, Licensed
3 Acupuncturist, Licensed Psychological Associate, and
4 Licensed Surgical Assistant.
5 . . .

6 [Sections 1451.055-1451.100 reserved for expansion]

7 SUBCHAPTER C. SELECTION OF PRACTITIONERS

8 Revised Law

9 Sec. 1451.101. DEFINITIONS. In this subchapter:

10 (1) "Health insurance policy" means a policy,
11 contract, or agreement described by Section 1451.102.

12 (2) "Insured" means an individual who is issued, is a
13 party to, or is a beneficiary under a health insurance policy.

14 (3) "Insurer" means an insurer, association, or
15 organization described by Section 1451.102.

16 (4) "Nurse first assistant" has the meaning assigned
17 by Section 301.1525, Occupations Code. (New; V.T.I.C. Art. 21.52,
18 Sec. 1 (part), as amended Acts 77th Leg., R.S., Ch. 812.)

19 Source Law

20 Sec. 1. . . .

21 (u) "nurse first assistant" has the
22 meaning assigned by Section 301.1525, Occupations
23 Code.

24 Revisor's Note

25 The definitions of "health insurance policy,"
26 "insured," and "insurer" are added to the revised law
27 for drafting convenience and to avoid unnecessary
28 repetition of the substance of the definitions.

29 Revised Law

30 Sec. 1451.102. APPLICABILITY OF SUBCHAPTER. Except as
31 provided by this subchapter, this subchapter applies only to an
32 individual, group, blanket, or franchise insurance policy,
33 insurance agreement, or group hospital service contract that
34 provides health benefits, accident benefits, or health and accident
35 benefits for medical or surgical expenses incurred as a result of an
36 accident or sickness and that is delivered, issued for delivery, or
37 renewed in this state by any incorporated or unincorporated
38 insurance company, association, or organization, including:

- 1 (1) a fraternal benefit society operating under
2 Chapter 885;
- 3 (2) a general casualty company operating under Chapter
4 861;
- 5 (3) a life, health, and accident insurance company
6 operating under Chapter 841 or 982;
- 7 (4) a Lloyd's plan operating under Chapter 941;
- 8 (5) a local mutual aid association operating under
9 Chapter 886;
- 10 (6) a mutual insurance company writing insurance other
11 than life insurance operating under Chapter 883;
- 12 (7) a mutual life insurance company operating under
13 Chapter 882;
- 14 (8) a reciprocal exchange operating under Chapter 942;
- 15 (9) a statewide mutual assessment company, mutual
16 assessment company, or mutual assessment life, health, and accident
17 association operating under Chapter 881 or 887; and
- 18 (10) a stipulated premium company operating under
19 Chapter 884. (V.T.I.C. Art. 21.52, Secs. 1 (part), 2, 3(a) (part).)

20 Source Law

21 Sec. 1. . . .

22 (a) "health insurance policy" means any
23 individual, group, blanket, or franchise insurance
24 policy, insurance agreement, or group hospital service
25 contract, providing benefits for medical or surgical
26 expenses incurred as a result of an accident or
27 sickness;

28 . . .
29 Sec. 2. This article applies to and embraces all
30 insurance companies, associations, and organizations,
31 whether incorporated or not, which provide health
32 benefits, accident benefits, or health and accident
33 benefits for medical or surgical expenses incurred as
34 a result of an accident or sickness. Without limiting
35 the foregoing, this article specifically applies to
36 the insurance companies, associations, and
37 organizations which come within the purview of the
38 following designated chapters of the Insurance Code:
39 Chapter 3, pertaining to life, health and accident
40 insurance companies; Chapter 8, pertaining to general
41 casualty companies; Chapter 10, pertaining to
42 fraternal benefit societies; Chapter 11, pertaining to
43 mutual life insurance companies; Chapter 12,
44 pertaining to local mutual aid associations; Chapters
45 13 and 14, pertaining to statewide mutual assessment
46 companies, mutual assessment companies, and mutual
47 assessment life, health and accident associations;

1 Chapter 15, pertaining to mutual insurance companies
2 writing other than life insurance; Chapter 18,
3 pertaining to underwriters making insurance on the
4 Lloyd's plan; Chapter 19, pertaining to reciprocal
5 exchanges; and Chapter 22, pertaining to stipulated
6 premium insurance companies.

7 Sec. 3. (a) . . . any health insurance policy
8 delivered, renewed, or issued for delivery in this
9 state by any insurance company, association, or
10 organization to which this article applies

11 Revisor's Note

12 (1) Section 2, V.T.I.C. Article 21.52, refers to
13 Chapter 3 of the Insurance Code. The relevant portions
14 of Chapter 3, relating to foreign and domestic
15 entities that may be authorized to write the
16 appropriate types of insurance, are revised in
17 Chapters 841 and 982 of this code. The revised law is
18 drafted accordingly.

19 (2) Section 2, V.T.I.C. Article 21.52, refers to
20 Chapter 14 of the Insurance Code. The relevant
21 portions of Chapter 14, relating to entities that may
22 be authorized to write the appropriate types of
23 insurance, are revised in Chapter 887 of this code. The
24 revised law is drafted accordingly.

25 Revised Law

26 Sec. 1451.103. CONFLICTING PROVISIONS VOID. (a) A
27 provision of a health insurance policy that conflicts with this
28 subchapter is void to the extent of the conflict.

29 (b) The presence in a health insurance policy of a provision
30 void under Subsection (a) does not affect the validity of other
31 policy provisions.

32 (c) An insurer shall bring each approved policy form that
33 contains a provision that conflicts with this subchapter into
34 compliance with this subchapter by use of:

35 (1) a rider or endorsement approved by the
36 commissioner; or

37 (2) a new or revised policy form approved by the
38 commissioner. (V.T.I.C. Art. 21.52, Sec. 3(e).)

1 Source Law

2 (e) Any provision in a health insurance policy
3 contrary to or in conflict with the provisions of this
4 article shall, to the extent of the conflict, be void,
5 but such invalidity shall not affect the validity of
6 the other provisions of this policy. Any presently
7 approved policy form containing any provision in
8 conflict with the requirements of this Act shall be
9 brought into compliance with this Act by the use of
10 riders and endorsements which have been approved by
11 the commissioner or by the filing of new or revised
12 policy forms for approval by the commissioner.

13 Revisor's Note

14 (1) Section 3(e), V.T.I.C. Article 21.52,
15 refers to "[a]ny provision . . . contrary to or in
16 conflict with the provisions of this article." The
17 revised law omits as unnecessary the reference to
18 "contrary to" because in this context "contrary to" is
19 included within the meaning of "in conflict with."

20 (2) Section 3(e), V.T.I.C. Article 21.52,
21 requires that a "presently" approved policy form be
22 brought into compliance with the article by use of
23 riders and endorsements or by filing a new or revised
24 policy form. At the time the article was originally
25 enacted, "presently" may have referred only to policy
26 forms approved before the original enactment of the
27 article. In that case, the provision could have been
28 omitted as executed law; however, a subsequent
29 amendment of Section 3 by Chapter 155, Acts of the 66th
30 Legislature, Regular Session, 1979, indicates that the
31 legislature intended that the provision have
32 continuing effect. As a result, the revised law omits
33 "presently."

34 Revised Law

35 Sec. 1451.104. NONDISCRIMINATORY PAYMENT OR REIMBURSEMENT;
36 EXCEPTION. (a) An insurer may not classify, differentiate, or
37 discriminate between scheduled services or procedures provided by a
38 health care practitioner selected under this subchapter and
39 performed in the scope of that practitioner's license and the same

1 services or procedures provided by another type of health care
2 practitioner whose services or procedures are covered by a health
3 insurance policy, in regard to:

4 (1) the payment schedule or payment provisions of the
5 policy; or

6 (2) the amount or manner of payment or reimbursement
7 under the policy.

8 (b) An insurer may not deny payment or reimbursement for
9 services or procedures in accordance with the policy payment
10 schedule or payment provisions solely because the services or
11 procedures were performed by a health care practitioner selected
12 under this subchapter.

13 (c) Notwithstanding Subsection (a), a health insurance
14 policy may provide for a different amount of payment or
15 reimbursement for scheduled services or procedures performed by an
16 advanced practice nurse, nurse first assistant, licensed surgical
17 assistant, or physician assistant if the methodology used to
18 compute the amount is the same as the methodology used to compute
19 the amount of payment or reimbursement when the services or
20 procedures are provided by a physician. (V.T.I.C. Art. 21.52, Secs.
21 3(c) (part), (d) (part), as amended Acts 77th Leg., R.S., Chs. 812,
22 1014.)

23 Source Law

24 (c) The payment or reimbursement by the
25 insurance company, association, or organization for
26 services or procedures in accordance with the payment
27 schedule or the payment provisions in the policy shall
28 not be denied because the same were performed
29 by

30 (d) There shall not be any classification,
31 differentiation, or other discrimination in the
32 payment schedule or the payment provisions in a health
33 insurance policy, nor in the amount or manner of
34 payment or reimbursement thereunder, between
35 scheduled services or procedures when performed
36 by . . . which fall within the scope of that
37 practitioner's license or certification and the same
38 services or procedures when performed by any other
39 practitioner of the healing arts whose services or
40 procedures are covered by the policy. However, a
41 health insurance policy may provide for a different
42 amount of payment or reimbursement for scheduled
43 services or procedures when performed by an advanced
44 practice nurse, a nurse first assistant, licensed

1 surgical assistant, or physician assistant provided
2 the reimbursement methodology used to calculate the
3 payment for the service or procedure is the same
4 methodology used to calculate the payment when the
5 service or procedure is provided by a physician.

6 Revisor's Note

7 (1) Sections 3(c) and (d), V.T.I.C. Article
8 21.52, list specific health care practitioners and
9 provide that an entity subject to the article may not
10 deny payment or reimbursement for the services or
11 procedures of those practitioners or discriminate
12 between services or procedures provided by the
13 specified practitioners and those provided by other
14 health care practitioners. The revised law omits the
15 lists of specific practitioners as unnecessary because
16 they duplicate the list of practitioners who may be
17 selected under this subchapter and defined by Section
18 3(a) of the article, revised as Sections
19 1451.105-1451.125. The omitted law reads:

20 (c) . . . a licensed doctor of
21 podiatric medicine, a licensed doctor of
22 optometry, a licensed doctor of
23 chiropractic, a licensed dentist, an
24 occupational therapist, a physical
25 therapist, a licensed audiologist, a
26 licensed speech-language pathologist, a
27 licensed master social worker--advanced
28 clinical practitioner, a licensed
29 dietitian, a licensed professional
30 counselor, a licensed marriage and family
31 therapist, a psychologist, a licensed
32 psychological associate, a licensed
33 chemical dependency counselor, an advanced
34 practice nurse, a nurse first assistant, a
35 physician assistant, a licensed
36 acupuncturist, or a licensed hearing
37 instrument fitter and dispenser.

38 (d) . . . a doctor of podiatric
39 medicine, a doctor of optometry, a doctor of
40 chiropractic, a licensed dentist, an
41 occupational therapist, a physical
42 therapist, a licensed audiologist, a
43 licensed speech-language pathologist, a
44 licensed master social worker--advanced
45 clinical practitioner, a licensed
46 dietitian, a licensed professional
47 counselor, a licensed marriage and family
48 therapist, a psychologist, a licensed
49 psychological associate, a licensed
50 chemical dependency counselor, an advanced
51 practice nurse to provide the services
52 scheduled in the policy, a nurse first
53 assistant to provide the services scheduled

1 in the policy and requested by the physician
2 whom the nurse is assisting, a physician
3 assistant to provide the services scheduled
4 in the policy, a licensed acupuncturist, or
5 a licensed hearing instrument fitter and
6 dispenser

7 (2) Section 3(d), V.T.I.C. Article 21.52,
8 refers to a practitioner's "license or certification."
9 The revised law omits "certification" as unnecessary
10 because each practitioner to which Article 21.52
11 applies (see Section 1 of the article, revised as
12 Section 1451.001) is required by law to obtain a
13 license.

14 Revised Law

15 Sec. 1451.105. SELECTION OF ACUPUNCTURIST. An insured may
16 select an acupuncturist to provide the services or procedures
17 scheduled in the health insurance policy that are within the scope
18 of the acupuncturist's license. (V.T.I.C. Art. 21.52, Sec. 3(a)
19 (part).)

20 Source Law

21 Sec. 3. (a) Any person who is issued, who is a
22 party to, or who is a beneficiary under [any health
23 insurance policy delivered, renewed, or issued for
24 delivery in this state by any insurance company,
25 association, or organization to which this article
26 applies] may select:

27 . . .
28 (13) a licensed acupuncturist to perform
29 the services or procedures scheduled in the policy
30 that fall within the scope of the license of that
31 practitioner;
32 . . .

33 Revised Law

34 Sec. 1451.106. SELECTION OF ADVANCED PRACTICE NURSE. An
35 insured may select an advanced practice nurse to provide the
36 services scheduled in the health insurance policy that are within
37 the scope of the nurse's license. (V.T.I.C. Art. 21.52, Sec. 3(a)
38 (part).)

39 Source Law

40 Sec. 3. (a) Any person who is issued, who is a
41 party to, or who is a beneficiary under [any health
42 insurance policy delivered, renewed, or issued for
43 delivery in this state by any insurance company,
44 association, or organization to which this article
45 applies] may select:

1 . . .
2 (14) an advanced practice nurse to provide
3 the services scheduled in the policy that fall within
4 the scope of the license of that practitioner;
5 . . .

6 Revised Law

7 Sec. 1451.107. SELECTION OF AUDIOLOGIST. An insured may
8 select an audiologist to measure hearing to determine the presence
9 or extent of the insured's hearing loss or provide aural
10 rehabilitation services to the insured if the insured has a hearing
11 loss and the services or procedures are scheduled in the health
12 insurance policy. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

13 Source Law

14 Sec. 3. (a) Any person who is issued, who is a
15 party to, or who is a beneficiary under [any health
16 insurance policy delivered, renewed, or issued for
17 delivery in this state by any insurance company,
18 association, or organization to which this article
19 applies] may select:

20 . . .
21 (5) a licensed audiologist to measure
22 hearing for the purpose of determining the presence or
23 extent of a hearing loss and to provide aural
24 rehabilitation services to a person with a hearing
25 loss if those services or procedures are scheduled in
26 the policy;
27 . . .

28 Revised Law

29 Sec. 1451.108. SELECTION OF CHEMICAL DEPENDENCY
30 COUNSELOR. An insured may select a chemical dependency counselor
31 to provide services or procedures scheduled in the health insurance
32 policy that are within the scope of the counselor's license.
33 (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

34 Source Law

35 Sec. 3. (a) Any person who is issued, who is a
36 party to, or who is a beneficiary under [any health
37 insurance policy delivered, renewed, or issued for
38 delivery in this state by any insurance company,
39 association, or organization to which this article
40 applies] may select:

41 . . .
42 (12) a licensed chemical dependency
43 counselor to perform the services or procedures
44 scheduled in the policy that fall within the scope of
45 the license of that practitioner;
46 . . .

47 Revised Law

48 Sec. 1451.109. SELECTION OF CHIROPRACTOR. An insured may

1 select a chiropractor to provide the medical or surgical services
2 or procedures scheduled in the health insurance policy that are
3 within the scope of the chiropractor's license. (V.T.I.C.
4 Art. 21.52, Sec. 3(a) (part).)

5 Source Law

6 Sec. 3. (a) Any person who is issued, who is a
7 party to, or who is a beneficiary under [any health
8 insurance policy delivered, renewed, or issued for
9 delivery in this state by any insurance company,
10 association, or organization to which this article
11 applies] may select:

12 (1) . . . a doctor of chiropractic to
13 perform the medical or surgical services or procedures
14 scheduled in the policy which fall within the scope of
15 the license of that practitioner;

16 . . .

17 Revised Law

18 Sec. 1451.110. SELECTION OF DENTIST. An insured may select
19 a dentist to provide the medical or surgical services or procedures
20 scheduled in the health insurance policy that are within the scope
21 of the dentist's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

22 Source Law

23 Sec. 3. (a) Any person who is issued, who is a
24 party to, or who is a beneficiary under [any health
25 insurance policy delivered, renewed, or issued for
26 delivery in this state by any insurance company,
27 association, or organization to which this article
28 applies] may select:

29 (1) . . . a licensed dentist, or . . . to
30 perform the medical or surgical services or procedures
31 scheduled in the policy which fall within the scope of
32 the license of that practitioner;

33 . . .

34 Revised Law

35 Sec. 1451.111. SELECTION OF DIETITIAN. An insured may
36 select a licensed dietitian or a provisionally licensed dietitian
37 acting under the supervision of a licensed dietitian to provide the
38 services scheduled in the health insurance policy that are within
39 the scope of the dietitian's license. (V.T.I.C. Art. 21.52, Sec.
40 3(a) (part).)

41 Source Law

42 Sec. 3. (a) Any person who is issued, who is a
43 party to, or who is a beneficiary under [any health
44 insurance policy delivered, renewed, or issued for
45 delivery in this state by any insurance company,
46 association, or organization to which this article

1 applies] may select:

2 . . .
3 (8) a licensed dietitian including a
4 provisional licensed dietitian under a licensed
5 dietitian's supervision to provide the services that
6 fall within the scope of the license of that dietitian
7 if those services are scheduled in the policy;
8 . . .

9 Revised Law

10 Sec. 1451.112. SELECTION OF HEARING INSTRUMENT FITTER AND
11 DISPENSER. An insured may select a hearing instrument fitter and
12 dispenser to provide the services or procedures scheduled in the
13 health insurance policy that are within the scope of the license of
14 the fitter and dispenser. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

15 Source Law

16 Sec. 3. (a) Any person who is issued, who is a
17 party to, or who is a beneficiary under [any health
18 insurance policy delivered, renewed, or issued for
19 delivery in this state by any insurance company,
20 association, or organization to which this article
21 applies] may select:

22 . . .
23 (16) a licensed hearing instrument fitter
24 and dispenser to provide the services or procedures
25 scheduled in the policy that fall within the scope of
26 the license of that practitioner;
27 . . .

28 Revised Law

29 Sec. 1451.113. SELECTION OF LICENSED MASTER SOCIAL
30 WORKER--ADVANCED CLINICAL PRACTITIONER. (a) An insured may
31 select a licensed master social worker--advanced clinical
32 practitioner to provide the services or procedures scheduled in the
33 health insurance policy that:

34 (1) are within the scope of the social worker's
35 license, including the provision of direct, diagnostic,
36 preventive, or clinical services to individuals, families, and
37 groups whose functioning is threatened or affected by social or
38 psychological stress or health impairment; and

39 (2) are specified as services under the terms of the
40 health insurance policy.

41 (b) The health insurance policy may require that services of
42 a licensed master social worker--advanced clinical practitioner
43 must be recommended by a physician. (V.T.I.C. Art. 21.52, Secs.

1 3(a) (part), (b) (part).)

2 Source Law

3 Sec. 3. (a) Any person who is issued, who is a
4 party to, or who is a beneficiary under [any health
5 insurance policy delivered, renewed, or issued for
6 delivery in this state by any insurance company,
7 association, or organization to which this article
8 applies] may select:

9
10 (7) a licensed master social
11 worker--advanced clinical practitioner to provide the
12 services that fall within the scope of the license of
13 such certified practitioner and which are specified as
14 services within the terms of the policy of insurance,
15 including the provision of direct, diagnostic,
16 preventive, or clinical services to individuals,
17 families, and groups whose functioning is threatened
18 or affected by social or psychological stress or
19 health impairment, if those services or procedures are
20 scheduled in the policy;

21
22 (b) The services of a licensed master social
23 worker--advanced clinical practitioner, . . . that
24 are included in this Act may require a professional
25 recommendation by a doctor of medicine or doctor of
26 osteopathy unless the health insurance policy terms do
27 not require such a recommendation.

28 Revised Law

29 Sec. 1451.114. SELECTION OF LICENSED PROFESSIONAL
30 COUNSELOR. (a) An insured may select a licensed professional
31 counselor to provide the services scheduled in the health insurance
32 policy that are within the scope of the counselor's license.

33 (b) The health insurance policy may require that services of
34 a licensed professional counselor must be recommended by a
35 physician. (V.T.I.C. Art. 21.52, Secs. 3(a) (part), (b) (part).)

36 Source Law

37 Sec. 3. (a) Any person who is issued, who is a
38 party to, or who is a beneficiary under [any health
39 insurance policy delivered, renewed, or issued for
40 delivery in this state by any insurance company,
41 association, or organization to which this article
42 applies] may select:

43
44 (9) a licensed professional counselor to
45 provide the services that fall within the scope of the
46 license of that professional if those services are
47 scheduled in the policy;

48
49 (b) The services of a . . . licensed
50 professional counselor, or . . . that are included in
51 this Act may require a professional recommendation by
52 a doctor of medicine or doctor of osteopathy unless the
53 health insurance policy terms do not require such a
54 recommendation.

1 Revised Law

2 Sec. 1451.115. SELECTION OF SURGICAL ASSISTANT. An
3 insured may select a surgical assistant to provide the services or
4 procedures scheduled in the health insurance policy that are within
5 the scope of the assistant's license. (V.T.I.C. Art. 21.52, Sec.
6 3(a) (part), as amended Acts 77th Leg., R.S., Ch. 1014.)

7 Source Law

8 Sec. 3. (a) Any person who is issued, who is a
9 party to, or who is a beneficiary under [any health
10 insurance policy delivered, renewed, or issued for
11 delivery in this state by any insurance company,
12 association, or organization to which this article
13 applies] may select:

14 . . .
15 (17) a licensed surgical assistant to
16 provide the services or procedures scheduled in the
17 policy that fall within the scope of the license of
18 that practitioner; or
19

20 Revised Law

21 Sec. 1451.116. SELECTION OF MARRIAGE AND FAMILY
22 THERAPIST. (a) An insured may select a marriage and family
23 therapist to provide the services scheduled in the health insurance
24 policy that are within the scope of the therapist's license.

25 (b) The health insurance policy may require that services of
26 a marriage and family therapist must be recommended by a physician.
27 (V.T.I.C. Art. 21.52, Secs. 3(a) (part), (b) (part).)

28 Source Law

29 Sec. 3. (a) Any person who is issued, who is a
30 party to, or who is a beneficiary under [any health
31 insurance policy delivered, renewed, or issued for
32 delivery in this state by any insurance company,
33 association, or organization to which this article
34 applies] may select:

35 . . .
36 (10) a licensed marriage and family
37 therapist to provide the services that fall within the
38 scope of the license of that professional if those
39 services are scheduled in the policy;

40 . . .
41 (b) The services of a . . . licensed marriage
42 and family therapist that are included in this Act may
43 require a professional recommendation by a doctor of
44 medicine or doctor of osteopathy unless the health
45 insurance policy terms do not require such a
46 recommendation.

47 Revised Law

48 Sec. 1451.117. SELECTION OF NURSE FIRST ASSISTANT. An

1 insured may select a nurse first assistant to provide the services
2 scheduled in the health insurance policy that:

- 3 (1) are within the scope of the nurse's license; and
- 4 (2) are requested by the physician whom the nurse is
5 assisting. (V.T.I.C. Art. 21.52, Sec. 3(a) (part), as amended Acts
6 77th Leg., R.S., Ch. 812.)

7 Source Law

8 Sec. 3. (a) Any person who is issued, who is a
9 party to, or who is a beneficiary under [any health
10 insurance policy delivered, renewed, or issued for
11 delivery in this state by any insurance company,
12 association, or organization to which this article
13 applies] may select:

- 14 . . .
- 15 (18) a nurse first assistant to provide
16 the services scheduled in the policy that:
 - 17 (A) fall within the scope of the
18 license of that practitioner; and
 - 19 (B) are requested by the physician
20 whom the nurse is assisting.

21 Revised Law

22 Sec. 1451.118. SELECTION OF OCCUPATIONAL THERAPIST. An
23 insured may select an occupational therapist to provide the
24 services scheduled in the health insurance policy that are within
25 the scope of the therapist's license. (V.T.I.C. Art. 21.52, Sec.
26 3(a) (part).)

27 Source Law

28 Sec. 3. (a) Any person who is issued, who is a
29 party to, or who is a beneficiary under [any health
30 insurance policy delivered, renewed, or issued for
31 delivery in this state by any insurance company,
32 association, or organization to which this article
33 applies] may select:

- 34 . . .
- 35 (3) an occupational therapist to provide
36 the services scheduled in the policy which fall within
37 the scope of the license of that occupational
38 therapist;
- 39 . . .

40 Revised Law

41 Sec. 1451.119. SELECTION OF OPTOMETRIST. An insured may
42 select an optometrist to provide the services or procedures
43 scheduled in the health insurance policy that are within the scope
44 of the optometrist's license. (V.T.I.C. Art. 21.52, Sec. 3(a)
45 (part).)

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Source Law

Sec. 3. (a) Any person who is issued, who is a party to, or who is a beneficiary under [any health insurance policy delivered, renewed, or issued for delivery in this state by any insurance company, association, or organization to which this article applies] may select:

. . .
(2) a licensed doctor of optometry to perform the services or procedures scheduled in the policy which fall within the scope of the license of that doctor of optometry;
. . .

Revised Law

Sec. 1451.120. SELECTION OF PHYSICAL THERAPIST. An insured may select a physical therapist to provide the services scheduled in the health insurance policy that are within the scope of the therapist's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

Source Law

Sec. 3. (a) Any person who is issued, who is a party to, or who is a beneficiary under [any health insurance policy delivered, renewed, or issued for delivery in this state by any insurance company, association, or organization to which this article applies] may select:

. . .
(4) a physical therapist to provide the services scheduled in the policy which fall within the scope of the license of that physical therapist;
. . .

Revised Law

Sec. 1451.121. SELECTION OF PHYSICIAN ASSISTANT. An insured may select a physician assistant to provide the services scheduled in the health insurance policy that are within the scope of the assistant's license. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

Source Law

Sec. 3. (a) Any person who is issued, who is a party to, or who is a beneficiary under [any health insurance policy delivered, renewed, or issued for delivery in this state by any insurance company, association, or organization to which this article applies] may select:

. . .
(15) a physician assistant to provide the services scheduled in the policy that fall within the scope of the license of that practitioner;
. . .

1 Revised Law

2 Sec. 1451.122. SELECTION OF PODIATRIST. An insured may
3 select a podiatrist to provide the medical or surgical services or
4 procedures scheduled in the health insurance policy that are within
5 the scope of the podiatrist's license. (V.T.I.C. Art. 21.52, Sec.
6 3(a) (part).)

7 Source Law

8 Sec. 3. (a) Any person who is issued, who is a
9 party to, or who is a beneficiary under [any health
10 insurance policy delivered, renewed, or issued for
11 delivery in this state by any insurance company,
12 association, or organization to which this article
13 applies] may select:

14 (1) a licensed doctor of podiatric
15 medicine, . . . to perform the medical or surgical
16 services or procedures scheduled in the policy which
17 fall within the scope of the license of that
18 practitioner;
19 . . .

20 Revised Law

21 Sec. 1451.123. SELECTION OF PSYCHOLOGICAL ASSOCIATE. An
22 insured may select a psychological associate to provide the
23 services scheduled in the health insurance policy that are within
24 the scope of the associate's license. (V.T.I.C. Art. 21.52, Sec.
25 3(a) (part), as amended Acts 77th Leg., R.S., Ch. 1014.)

26 Source Law

27 Sec. 3. (a) Any person who is issued, who is a
28 party to, or who is a beneficiary under [any health
29 insurance policy delivered, renewed, or issued for
30 delivery in this state by any insurance company,
31 association, or organization to which this article
32 applies] may select:

33 . . .
34 (18) a licensed psychological associate to
35 provide the services that fall within the scope of the
36 license of that professional if those services are
37 scheduled in the policy.

38 Revised Law

39 Sec. 1451.124. SELECTION OF PSYCHOLOGIST. An insured may
40 select a psychologist to provide the services or procedures
41 scheduled in the health insurance policy that are within the scope
42 of the psychologist's license. (V.T.I.C. Art. 21.52, Sec. 3(a)
43 (part).)

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Source Law

Sec. 3. (a) Any person who is issued, who is a party to, or who is a beneficiary under [any health insurance policy delivered, renewed, or issued for delivery in this state by any insurance company, association, or organization to which this article applies] may select:

- . . .
- (11) a psychologist to perform the services or procedures scheduled in the policy that fall within the scope of the license of that psychologist;
- . . .

Revised Law

Sec. 1451.125. SELECTION OF SPEECH-LANGUAGE PATHOLOGIST. An insured may select a speech-language pathologist to evaluate speech or language, provide habilitative or rehabilitative services to restore speech or language loss, or correct a speech or language impairment if the services or procedures are scheduled in the health insurance policy. (V.T.I.C. Art. 21.52, Sec. 3(a) (part).)

Source Law

Sec. 3. (a) Any person who is issued, who is a party to, or who is a beneficiary under [any health insurance policy delivered, renewed, or issued for delivery in this state by any insurance company, association, or organization to which this article applies] may select:

- . . .
- (6) a licensed speech-language pathologist to evaluate speech and language and to provide habilitative and rehabilitative services to restore speech or language loss or to correct a speech or language impairment if those services or procedures are scheduled in the policy;
- . . .

Revised Law

Sec. 1451.126. REIMBURSEMENT FOR PHYSICAL MODALITIES AND PROCEDURES BY HEALTH INSURER, ADMINISTRATOR, HEALTH MAINTENANCE ORGANIZATION, OR PREFERRED PROVIDER BENEFIT PLAN ISSUER. (a) A health insurer or licensed third-party administrator may not deny reimbursement to a health care practitioner for the provision of covered services of physical modalities and procedures that are within the scope of the practitioner's practice if the services are performed in strict compliance with:

- (1) laws and rules related to that practitioner's

1 license; and

2 (2) the terms of the insurance policy or other
3 coverage agreement.

4 (b) A health maintenance organization or preferred provider
5 benefit plan issuer may not deny reimbursement to a participating
6 health care practitioner for services provided under a coverage
7 agreement solely because of the type of practitioner providing the
8 services if the services are performed in strict compliance with:

9 (1) laws and rules related to that practitioner's
10 license; and

11 (2) the terms of the insurance policy or other
12 coverage agreement.

13 (c) This section may not be construed to circumvent any
14 contractual provider network agreement between a health insurer or
15 third-party administrator and a licensed health care practitioner.
16 (V.T.I.C. Art. 21.52, Sec. 3A.)

17 Source Law

18 Sec. 3A. (a) A health insurer or licensed third
19 party administrator may not deny reimbursement to a
20 practitioner for the provision of covered services of
21 physical modalities and procedures that are within the
22 scope of such practitioner's practice provided such
23 services are performed in strict conformity with
24 applicable laws and regulations relating to the
25 licensure of the practitioner and with the terms of the
26 insurance policy or other coverage agreement.

27 (b) A health maintenance organization or
28 preferred provider organization may not deny
29 reimbursement to a participating practitioner for
30 services provided pursuant to a coverage agreement
31 solely because of the type of practitioner who
32 provided such services as long as the services are
33 performed in strict conformity with applicable laws
34 and regulations relating to the licensure of the
35 practitioner and with the terms of the insurance
36 policy or other coverage agreement.

37 (c) Nothing herein shall be construed to
38 circumvent contractual provider network agreements
39 between a health insurer or a third party
40 administrator and licensed practitioners.

41 Revisor's Note

42 (1) Sections 3A(a) and (b), V.T.I.C. Article
43 21.52, refer to "regulations." The revised law
44 substitutes the term "rules" for "regulations" because
45 in context the terms are synonymous, and because under

1 Section 311.005(5), Government Code (Code
2 Construction Act), a rule is defined to include a
3 regulation. That definition applies to the revised
4 law.

5 (2) Section 3A(b), V.T.I.C. Article 21.52,
6 provides that a "health maintenance organization or
7 preferred provider organization" may not deny
8 reimbursement in certain circumstances. The revised
9 law substitutes "preferred provider benefit plan
10 issuer" for "preferred provider organization" for
11 clarity and consistency with terminology used in this
12 code. In context, it is apparent that the provision is
13 intended to apply to an entity that issues a preferred
14 provider benefit plan.

15 Revised Law

16 Sec. 1451.127. DUTY OF PERSON ARRANGING PROVIDER CONTRACTS
17 FOR HEALTH INSURER OR HEALTH MAINTENANCE ORGANIZATION. (a) A
18 person who arranges contracts with providers on behalf of a health
19 maintenance organization or health insurer shall comply with laws
20 related to the duties of the organization or insurer to notify and
21 consider providers for those contracts.

22 (b) A violation of this section:

23 (1) is an unlawful practice under Section 15.05,
24 Business & Commerce Code; and

25 (2) constitutes restraint of trade. (V.T.I.C.
26 Art. 21.52, Sec. 4.)

27 Source Law

28 Sec. 4. Each person who arranges contracts with
29 providers on behalf of a health maintenance
30 organization or health insurer shall comply with laws
31 relating to the duties of the health maintenance
32 organization or health insurer to notify and consider
33 providers for those contracts. A violation of this
34 section constitutes restraint of trade and is an
35 unlawful practice under Section 15.05, Business &
36 Commerce Code.

37 [Sections 1451.128-1451.150 reserved for expansion]

1 SUBCHAPTER D. ACCESS TO OPTOMETRISTS AND OPHTHALMOLOGISTS
2 USED UNDER MANAGED CARE PLAN

3 Revised Law

4 Sec. 1451.151. DEFINITIONS. In this subchapter:

5 (1) "Managed care plan" means a plan under which a
6 health maintenance organization, preferred provider benefit plan
7 issuer, or other organization provides or arranges for health care
8 benefits to plan participants and requires or encourages plan
9 participants to use health care practitioners the plan designates.

10 (2) "Ophthalmologist" means a physician who
11 specializes in ophthalmology. (V.T.I.C. Art. 21.52D, Sec. (a).)

12 Source Law

13 Art. 21.52D. (a) In this article:

14 (1) "Managed care plan" means a health
15 maintenance organization, a preferred provider
16 organization, or another organization that provides or
17 arranges for health care benefits to participants and
18 that requires or encourages participants to use health
19 care practitioners designated by the plan.

20 (2) "Ophthalmologist" means a physician
21 who is licensed by the Texas State Board of Medical
22 Examiners and who specializes in ophthalmology.

23 Revisor's Note

24 Section (a)(1), V.T.I.C. Article 21.52D, refers
25 to a "preferred provider organization." The revised
26 law substitutes "preferred provider benefit plan
27 issuer" for "preferred provider organization" for the
28 reason stated in Revisor's Note (2) to Section
29 1451.126.

30 Revised Law

31 Sec. 1451.152. APPLICABILITY AND CONSTRUCTION OF
32 SUBCHAPTER. (a) This subchapter applies only to a managed care
33 plan that provides or arranges for benefits for vision or medical
34 eye care services or procedures that are within the scope of an
35 optometrist's or therapeutic optometrist's license.

36 (b) This subchapter does not require a managed care plan to
37 provide vision or medical eye care services or procedures.
38 (V.T.I.C. Art. 21.52D, Secs. (b) (part), (c).)

1 Source Law

2 (b) A managed care plan . . . may not:

3 (1) discriminate against a health care
4 practitioner because the practitioner is an
5 optometrist, therapeutic optometrist, or
6 ophthalmologist;

7 (2) fail to include optometrists,
8 therapeutic optometrists, and ophthalmologists as
9 participating practitioners in the plan;

10 (3) restrict or discourage a participant
11 from obtaining covered vision or medical eye care
12 services or procedures from a participating
13 optometrist, therapeutic optometrist, or
14 ophthalmologist because the practitioner is an
15 optometrist, therapeutic optometrist, or
16 ophthalmologist;

17 (4) fail to include the name of a
18 participating optometrist, therapeutic optometrist,
19 or ophthalmologist on a list of participating
20 practitioners or fail to give equal prominence to the
21 name;

22 (5) fail to include an optometrist,
23 therapeutic optometrist, or ophthalmologist as a
24 participating practitioner in the plan because the
25 optometrist, therapeutic optometrist, or
26 ophthalmologist does not have medical staff privileges
27 at a hospital or at a particular hospital; or

28 (6) fail to include an optometrist,
29 therapeutic optometrist, or ophthalmologist as a
30 participating practitioner in the plan because the
31 services or procedures provided by the optometrist,
32 therapeutic optometrist, or ophthalmologist may be
33 provided by another type of practitioner.

34 [Sections 1451.154-1451.200 reserved for expansion]

35 SUBCHAPTER E. DENTAL CARE BENEFITS IN HEALTH INSURANCE

36 POLICIES OR EMPLOYEE BENEFIT PLANS

37 Revised Law

38 Sec. 1451.201. DEFINITIONS. In this subchapter:

39 (1) "Dental care service" means a service provided to
40 a person to prevent, alleviate, cure, or heal a human dental illness
41 or injury.

42 (2) "Employee benefit plan" means a plan, fund, or
43 program established or maintained by an employer or employee
44 organization.

45 (3) "Health insurance policy" means any individual,
46 group, blanket, or franchise insurance policy, insurance
47 agreement, or group hospital service contract. (V.T.I.C.
48 Art. 21.53, Sec. 1 (part).)

1 SUBCHAPTER. (a) This subchapter applies only to an employee
2 benefit plan or health insurance policy delivered, issued for
3 delivery, renewed, or contracted for in this state to the extent
4 that:

5 (1) the employee benefit plan is established or
6 maintained to provide dental care services, through insurance or
7 otherwise, for the plan's participants or the beneficiaries of the
8 plan's participants; or

9 (2) the health insurance policy provides benefits for
10 dental care services.

11 (b) This subchapter does not apply to a health maintenance
12 organization governed by Chapter 843.

13 (c) The exemptions and exceptions of Sections 881.002 and
14 881.004 and Article 21.41 do not apply to this subchapter.

15 (d) This subchapter does not require an employee benefit
16 plan or health insurance policy to provide any type of benefits for
17 dental care expenses. (V.T.I.C. Art. 21.53, Secs. 1(a) (part), (b)
18 (part), 4 (part), 5, 6.)

19 Source Law

20 Sec. 1. . . .

21 (a) . . . providing benefits for dental
22 care services;

23 (b) . . . to the extent that such plan,
24 fund, or program was established or is maintained for
25 the purpose of providing for its participants or their
26 beneficiaries, through the purchase of insurance or
27 otherwise, benefits for dental care services;

28 . . .

29 Sec. 4. . . . which is delivered, renewed,
30 issued for delivery, or otherwise contracted for in
31 this state

32 Sec. 5. The exemptions and exceptions in
33 Articles 13.09 and 21.41 of the Insurance Code do not
34 apply to this article. The provisions of this article
35 do not apply to health maintenance organizations as
36 defined and regulated by Chapter 20A of the Insurance
37 Code.

38 Sec. 6. The provisions of this article do not
39 mandate that any type of benefits for dental care
40 expenses be provided by a health insurance policy or an
41 employee benefit plan.

42 Revised Law

43 Sec. 1451.203. CONFLICTING PROVISIONS. A provision of an
44 employee benefit plan or health insurance policy that conflicts

1 with this subchapter is void to the extent of the conflict.
2 (V.T.I.C. Art. 21.53, Sec. 4 (part).)

3 Source Law

4 Sec. 4. Any provision in a health insurance
5 policy or employee benefit plan . . . which is
6 contrary to this article shall to the extent of such
7 conflict be void.

8 Revised Law

9 Sec. 1451.204. CERTAIN CONDUCT PERMITTED. (a)
10 Notwithstanding any other provision of this subchapter, a dentist
11 may contract directly with a patient to provide dental care
12 services to the patient as authorized by law.

13 (b) Notwithstanding any other provision of this subchapter,
14 a person providing a health insurance policy or employee benefit
15 plan or an employer or an employee organization may:

16 (1) make information available to its insureds,
17 beneficiaries, participants, employees, or members regarding
18 dental care services through the distribution of factually accurate
19 information about dental care services and the rates, fees,
20 locations, and hours for the services if the information is
21 distributed on the request of a dentist;

22 (2) establish an administrative mechanism to
23 facilitate payments for dental care services from an insured,
24 beneficiary, participant, employee, or member to a dentist chosen
25 by the insured, beneficiary, participant, employee, or member; or

26 (3) nondiscriminatorily pay or reimburse its insured,
27 beneficiary, participant, employee, or member for the cost of
28 dental care services provided by a dentist chosen by the insured,
29 beneficiary, participant, employee, or member. (V.T.I.C.
30 Art. 21.53, Sec. 7.)

31 Source Law

32 Sec. 7. The provisions of this article do not
33 prohibit the following conduct and shall be construed
34 to provide that:

35 (a) a dentist may contract directly with a
36 patient for the furnishing of dental care services to
37 said patient as may be otherwise authorized by law;

38 (b) any person providing a health
39 insurance policy or employee benefit plan, or an

1 employer, or an employee organization may:

2 (1) make available to its insureds,
3 beneficiaries, participants, employees, or members
4 information relating to dental care services by the
5 distribution of factually accurate information
6 regarding dental care services, rates, fees, location,
7 and hours of service, provided such distribution is
8 made upon the request of any dentist licensed by this
9 state; or

10 (2) establish an administrative
11 mechanism which facilitates payment for dental care
12 services by insureds, beneficiaries, participants,
13 employees, or members to the dentist of their choice;
14 or

15 (3) pay or reimburse, on a
16 nondiscriminatory basis, its insureds, beneficiaries,
17 participants, employees, or members for the cost of
18 dental care services rendered by the dentist of their
19 choice.

20 Revised Law

21 Sec. 1451.205. DISCLOSURE OF BENEFIT TERMS. An employee
22 benefit plan or health insurance policy shall:

23 (1) if applicable, disclose that the benefit for
24 dental care services offered is limited to the least costly
25 treatment; and

26 (2) specify in dollars and cents the amount of the
27 payment or reimbursement to be provided for dental care services or
28 define and explain the standard on which payment of benefits or
29 reimbursement for the cost of dental care services is based, such
30 as:

31 (A) "usual and customary" fees;

32 (B) "reasonable and customary" fees;

33 (C) "usual, customary, and reasonable" fees; or

34 (D) words of similar meaning. (V.T.I.C.

35 Art. 21.53, Sec. 3 (part).)

36 Source Law

37 Sec. 3. Any health insurance policy or employee
38 benefit plan which is delivered, renewed, issued for
39 delivery, or otherwise contracted for in this state
40 shall, to the extent that it provides benefits for
41 dental care services:

42 (a) disclose, if applicable, that the
43 benefit offered is limited to the least costly
44 treatment;

45 (b) define and explain the standard upon
46 which the payment of benefits or reimbursement for the
47 cost of dental care services is based, such as "usual
48 and customary," "reasonable and customary," "usual,
49 customary, and reasonable," fees or words of similar
50 import or specify in dollars and cents the amount of

1 the payment or reimbursement for dental care services
2 to be provided. . . .

3 Revised Law

4 Sec. 1451.206. PAYMENT OR REIMBURSEMENT OF DENTIST. (a)

5 The employee benefit plan or health insurance policy shall provide:

6 (1) that payment or reimbursement for a noncontracting
7 provider dentist shall be the same as payment or reimbursement for a
8 contracting provider dentist; and

9 (2) that the party to or beneficiary of the plan or
10 policy may assign the right to payment or reimbursement to the
11 dentist who provides the dental care services.

12 (b) Notwithstanding Subsection (a)(1), the employee benefit
13 plan or health insurance policy is not required to make payment or
14 reimbursement in an amount greater than:

15 (1) the amount specified in the plan or policy; or

16 (2) the fee the providing dentist charges for the
17 dental care services provided.

18 (c) If the right to payment or reimbursement is assigned as
19 provided by Subsection (a)(2):

20 (1) payment or reimbursement shall be made directly to
21 the designated dentist; and

22 (2) direct payment to the designated dentist
23 discharges the payor's obligation. (V.T.I.C. Art. 21.53, Sec. 3
24 (part).)

25 Source Law

26 Sec. 3. Any health insurance policy or employee
27 benefit plan . . . shall . . .

28 (b) . . . Said payment or reimbursement
29 for a noncontracting provider dentist shall be the
30 same as the payment or reimbursement for a contracting
31 provider dentist; provided, however, that the health
32 insurance policy or the employee benefit plan shall
33 not be required to make payment or reimbursement in an
34 amount which is greater than the amount so specified or
35 which is greater than the fee charged by the providing
36 dentist for the dental care services rendered; and

37 (c) provide that the party to or
38 beneficiary of the health insurance policy or employee
39 benefit plan may assign the right to benefits to the
40 dentist who provides the dental care services, in
41 which case, benefits shall be paid directly to the
42 dentist designated. A payment made pursuant to this
43 subsection discharges the payor's obligation to pay
44 those benefits.

1 Revised Law

2 Sec. 1451.207. PROHIBITED CONDUCT. (a) An employee
3 benefit plan or health insurance policy may not:

4 (1) interfere with or prevent an individual who is a
5 party to or beneficiary of the plan or policy from selecting a
6 dentist of the individual's choice to provide a dental care service
7 the plan or policy offers if the dentist selected is licensed in
8 this state to provide the service;

9 (2) deny a dentist the right to participate as a
10 contracting provider under the plan or policy if the dentist is
11 licensed to provide the dental care services the plan or policy
12 offers;

13 (3) authorize a person to regulate, interfere with, or
14 intervene in the provision of dental care services a dentist
15 provides a patient, including diagnosis, if the dentist practices
16 within the scope of the dentist's license; or

17 (4) require a dentist to make or obtain a dental x-ray
18 or other diagnostic aid in providing dental care services.

19 (b) Subsection (a)(4) does not prohibit a request for an
20 existing dental x-ray or other existing diagnostic aid for a
21 determination of benefits payable under an employee benefit plan or
22 health insurance policy.

23 (c) This section does not prohibit the predetermination of
24 benefits for dental care expenses before the attending dentist
25 provides treatment. (V.T.I.C. Art. 21.53, Sec. 2.)

26 Source Law

27 Sec. 2. No health insurance policy or employee
28 benefit plan which is delivered, renewed, issued for
29 delivery, or otherwise contracted for in this state
30 shall:

31 (a) prevent any person who is a party to or
32 beneficiary of any such health insurance policy or
33 employee benefit plan from selecting the dentist of
34 his choice to furnish the dental care services offered
35 by said policy or plan or interfere with said selection
36 provided the dentist is licensed to furnish such
37 dental care services in this state;

38 (b) deny any dentist the right to
39 participate as a contracting provider for such policy
40 or plan provided the dentist is licensed to furnish the
41 dental care services offered by said policy or plan;

1 (c) authorize any person to regulate,
2 interfere, or intervene in any manner in the diagnosis
3 or treatment rendered by a dentist to his patient for
4 the purpose of preventing, alleviating, curing, or
5 healing dental illness or injury provided said dentist
6 practices within the scope of his license; or

7 (d) require that any dentist furnishing
8 dental care services must make or obtain dental x-rays
9 or any other diagnostic aids for the purpose of
10 preventing, alleviating, curing, or healing dental
11 illness or injury; provided, however, that nothing
12 herein shall prohibit requests for existing dental
13 x-rays or any other existing diagnostic aids for the
14 purpose of determining benefits payable under a health
15 insurance policy or employee benefit plan.

16 Nothing herein shall prohibit the
17 predetermination of benefits for dental care expenses
18 prior to treatment by the attending dentist.

19 [Sections 1451.208-1451.250 reserved for expansion]

20 SUBCHAPTER F. ACCESS TO OBSTETRICAL OR GYNECOLOGICAL CARE

21 Revised Law

22 Sec. 1451.251. DEFINITION. In this subchapter, "enrollee"
23 means an individual enrolled in a health benefit plan. (V.T.I.C.
24 Art. 21.53D, Sec. 1(1), as added Acts 75th Leg., R.S., Ch. 912.)

25 Source Law

26 Art. 21.53D

27 Sec. 1. In this article:

28 (1) "Enrollee" means an individual
29 enrolled in a health benefit plan.

30 Revisor's Note

31 (1) Section 1(2), V.T.I.C. Article 21.53D, as
32 added by Chapter 912, Acts of the 75th Legislature,
33 Regular Session, 1997, defines "health benefit plan."
34 The revised law omits the definition as unnecessary
35 because Section 2 of that article, revised as Sections
36 1451.252 and 1451.253, specifies the types of health
37 benefit plans to which this subchapter applies, and
38 thus the defined term is not helpful to the reader.
39 The omitted law reads:

40 (2) "Health benefit plan" means
41 a plan described in Section 2 of this
42 article.

43 (2) Section 1(3), V.T.I.C. Article 21.53D, as
44 added by Chapter 912, Acts of the 75th Legislature,
45 Regular Session, 1997, defines "physician." The

1 revised law omits the definition as unnecessary
2 because it duplicates the definition of the term as
3 revised in Section 1451.001, which applies throughout
4 this chapter. The omitted law reads:

5 (3) "Physician" means a person
6 licensed as a physician by the Texas State
7 Board of Medical Examiners.

8 Revised Law

9 Sec. 1451.252. APPLICABILITY OF SUBCHAPTER. This
10 subchapter applies only to a health benefit plan that requires an
11 enrollee to obtain certain specialty health care services through a
12 referral made by a primary care physician or other gatekeeper and
13 that:

14 (1) provides benefits for medical or surgical expenses
15 incurred as a result of a health condition, accident, or sickness,
16 including:

17 (A) an individual, group, blanket, or franchise
18 insurance policy or insurance agreement, a group hospital service
19 contract, or an individual or group evidence of coverage that is
20 offered by:

21 (i) an insurance company;

22 (ii) a group hospital service corporation
23 operating under Chapter 842;

24 (iii) a fraternal benefit society operating
25 under Chapter 885;

26 (iv) a stipulated premium company operating
27 under Chapter 884; or

28 (v) a health maintenance organization
29 operating under Chapter 843; and

30 (B) to the extent permitted by the Employee
31 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et
32 seq.), a health benefit plan that is offered by:

33 (i) a multiple employer welfare arrangement
34 as defined by Section 3 of that Act; or

35 (ii) another analogous benefit

1 arrangement;

2 (2) is offered by:

3 (A) an approved nonprofit health corporation
4 that holds a certificate of authority under Chapter 844; or

5 (B) an entity that is not authorized under this
6 code or another insurance law of this state that contracts directly
7 for health care services on a risk-sharing basis, including a
8 capitation basis; or

9 (3) provides health and accident coverage through a
10 risk pool created under Chapter 172, Local Government Code,
11 notwithstanding Section 172.014, Local Government Code, or any
12 other law. (V.T.I.C. Art. 21.53D, Secs. 2(a), (b), (d), as added
13 Acts 75th Leg., R.S., Ch. 912.)

14 Source Law

15 Sec. 2. (a) This article applies to a health
16 benefit plan that:

17 (1) provides benefits for medical or
18 surgical expenses incurred as a result of a health
19 condition, accident, or sickness, including:

20 (A) an individual, group, blanket, or
21 franchise insurance policy or insurance agreement, a
22 group hospital service contract, or an individual or
23 group evidence of coverage that is offered by:

24 (i) an insurance company;

25 (ii) a group hospital service
26 corporation operating under Chapter 20 of this code;

27 (iii) a fraternal benefit
28 society operating under Chapter 10 of this code;

29 (iv) a stipulated premium
30 insurance company operating under Chapter 22 of this
31 code; or

32 (v) a health maintenance
33 organization operating under the Texas Health
34 Maintenance Organization Act (Chapter 20A, Vernon's
35 Texas Insurance Code); and

36 (B) to the extent permitted by the
37 Employee Retirement Income Security Act of 1974 (29
38 U.S.C. Section 1001 et seq.), a health benefit plan
39 that is offered by:

40 (i) a multiple employer welfare
41 arrangement as defined by Section 3, Employee
42 Retirement Income Security Act of 1974 (29 U.S.C.
43 Section 1002); or

44 (ii) another analogous benefit
45 arrangement;

46 (2) is offered by an approved nonprofit
47 health corporation that is certified under Section
48 5.01(a), Medical Practice Act (Article 4495b, Vernon's
49 Texas Civil Statutes), and that holds a certificate of
50 authority issued by the commissioner under Article
51 21.52F of this code; or

52 (3) is offered by any other entity not
53 licensed under this code or another insurance law of

1 this state that contracts directly for health care
2 services on a risk-sharing basis, including an entity
3 that contracts for health care services on a
4 capitation basis.

5 (b) Notwithstanding Section 172.014, Local
6 Government Code, or any other law, this article
7 applies to health and accident coverage provided by a
8 risk pool created under Chapter 172, Local Government
9 Code.

10 (d) This article applies to each health benefit
11 plan that requires an enrollee to obtain certain
12 specialty health care services through a referral made
13 by a primary care physician or other gatekeeper.

14 Revisor's Note

15 (1) Section 2(a)(2), V.T.I.C. Article 21.53D,
16 as added by Chapter 912, Acts of the 75th Legislature,
17 Regular Session, 1997, refers to an approved nonprofit
18 health corporation that is "certified under Section
19 5.01(a), Medical Practice Act" and holds a certificate
20 of authority "issued by the commissioner under Article
21 21.52F." The revised law omits the reference to
22 certification under Section 5.01(a), Medical Practice
23 Act (Article 4495b, Vernon's Texas Civil Statutes),
24 which was codified in 1999 in Chapter 162, Occupations
25 Code, as unnecessary because V.T.I.C. Article 21.52F,
26 revised as Chapter 844 of this code, requires a
27 nonprofit corporation to be certified under that
28 provision as a condition of holding a certificate of
29 authority. The revised law also omits as unnecessary
30 the reference to the commissioner issuing the
31 certificate of authority because Chapter 844 requires
32 the commissioner to issue the certificate of
33 authority.

34 (2) Section 2(a)(3), V.T.I.C. Article 21.53D,
35 as added by Chapter 912, Acts of the 75th Legislature,
36 Regular Session, 1997, refers to a health benefit plan
37 offered by an entity that is not "licensed" under the
38 Insurance Code or another insurance law of this state.
39 The revised law substitutes "authorized" for
40 "licensed" for consistency with terminology used

1 throughout this code.

2 Revised Law

3 Sec. 1451.253. EXCEPTION. This subchapter does not apply
4 to:

5 (1) a plan that provides coverage:

6 (A) only for a specified disease;

7 (B) only for accidental death or dismemberment;

8 (C) for wages or payments instead of wages for a
9 period during which an employee is absent from work because of
10 sickness or injury; or

11 (D) as a supplement to a liability insurance
12 policy;

13 (2) a small employer health benefit plan written under
14 Chapter 1501;

15 (3) a Medicare supplemental policy as defined by
16 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

17 (4) a workers' compensation insurance policy;

18 (5) medical payment insurance coverage provided under
19 a motor vehicle insurance policy;

20 (6) a long-term care insurance policy, including a
21 nursing home fixed indemnity policy, unless the commissioner
22 determines that the policy provides benefit coverage so
23 comprehensive that the policy is a health benefit plan as described
24 by Section 1451.252; or

25 (7) any health benefit plan that does not provide:

26 (A) benefits related to pregnancy; or

27 (B) well-woman care benefits. (V.T.I.C.
28 Art. 21.53D, Sec. 2(c), as added Acts 75th Leg., R.S., Ch. 912.)

29 Source Law

30 (c) This article does not apply to:

31 (1) a plan that provides coverage:

32 (A) only for a specified disease;

33 (B) only for accidental death or
34 dismemberment;

35 (C) for wages or payments in lieu of
36 wages for a period during which an employee is absent
37 from work because of sickness or injury; or

38 (D) as a supplement to liability

1 insurance;
2 (2) a plan written under Chapter 26 of this
3 code;
4 (3) a Medicare supplemental policy as
5 defined by Section 1882(g)(1), Social Security Act (42
6 U.S.C. Section 1395ss);
7 (4) workers' compensation insurance
8 coverage;
9 (5) medical payment insurance issued as a
10 part of a motor vehicle insurance policy;
11 (6) a long-term care policy, including a
12 nursing home fixed indemnity policy, unless the
13 commissioner determines that the policy provides
14 benefit coverage so comprehensive that the policy is a
15 health benefit plan as described by Subsection (a) of
16 this section;
17 (7) any health benefit plan that does not
18 provide pregnancy-related benefits; or
19 (8) any health benefit plan that does not
20 provide well-woman care benefits.

21 Revisor's Note

22 Section 2(c)(2), V.T.I.C. Article 21.53D, as
23 added by Chapter 912, Acts of the 75th Legislature,
24 Regular Session, 1997, refers to "a plan written under
25 Chapter 26 of this code." The revised law refers to a
26 "small employer health benefit plan written under
27 Chapter 1501." When Article 21.53D was enacted,
28 Chapter 26, codified as Chapter 1501 of this code,
29 addressed only benefit plans offered by small
30 employers. Provisions addressing benefit plans
31 offered by large employers were later added to Chapter
32 26 through the enactment of Chapter 955, Acts of the
33 75th Legislature, Regular Session, 1997.
34 Consequently, the reference to "a small employer
35 health benefit plan" correctly reflects legislative
36 intent.

37 Revised Law

38 Sec. 1451.254. RULES. The commissioner shall adopt rules
39 necessary to implement this subchapter. (V.T.I.C. Art. 21.53D,
40 Sec. 6, as added Acts 75th Leg., R.S., Ch. 912.)

41 Source Law

42 Sec. 6. The commissioner shall adopt rules as
43 necessary to implement this article.

1 Revised Law

2 Sec. 1451.255. RIGHT OF FEMALE ENROLLEE TO SELECT
3 OBSTETRICIAN OR GYNECOLOGIST. (a) Except as provided by
4 Subsection (b), a health benefit plan shall permit a female
5 enrollee to select, in addition to a primary care physician, an
6 obstetrician or gynecologist to provide the enrollee with health
7 care services that are within the scope of the professional
8 specialty practice of a properly credentialed obstetrician or
9 gynecologist.

10 (b) A health benefit plan may limit an enrollee's
11 self-referral under Subsection (a) to only one participating
12 obstetrician or gynecologist to provide both gynecological and
13 obstetrical care to the enrollee. This subsection does not affect
14 the right of an enrollee to select the physician who provides that
15 care.

16 (c) This section does not preclude an enrollee from
17 selecting a qualified physician, including a family physician or
18 internal medicine physician, to provide the enrollee with health
19 care services described by Subsection (a).

20 (d) This section does not affect the authority of a health
21 benefit plan issuer to establish selection criteria regarding other
22 physicians who provide services under the plan. (V.T.I.C.
23 Art. 21.53D, Secs. 3(a), (c), 4(e), as added Acts 75th Leg., R.S.,
24 Ch. 912.)

25 Source Law

26 Sec. 3. (a) Each health benefit plan subject
27 to this article shall permit a woman who is entitled to
28 coverage under the plan to select, in addition to a
29 primary care physician, an obstetrician or
30 gynecologist to provide health care services within
31 the scope of the professional specialty practice of a
32 properly credentialed obstetrician or gynecologist.
33 This section does not preclude a woman from selecting a
34 family physician, internal medicine physician, or
35 other qualified physician to provide that care.

36 (c) This section does not affect the authority
37 of a health benefit plan to establish selection
38 criteria regarding other physicians who provide
39 services through the plan.

40 [Sec. 4]

1 (e) In implementing the access required under
2 Section 3 of this article, a health benefit plan may
3 limit a woman enrolled in the plan to self-referral to
4 one participating obstetrician and gynecologist for
5 both gynecological care and obstetrical care. This
6 subsection does not affect the right of the woman to
7 select the physician who provides that care.

8 Revised Law

9 Sec. 1451.256. DIRECT ACCESS TO SERVICES OF OBSTETRICIAN OR
10 GYNECOLOGIST. (a) In this section, "health care services"
11 includes:

- 12 (1) one well-woman examination each year;
- 13 (2) care related to pregnancy;
- 14 (3) care for any active gynecological condition; and
- 15 (4) diagnosis, treatment, and referral for any disease
16 or condition that is within the scope of the professional specialty
17 practice of a properly credentialed obstetrician or gynecologist.

18 (b) In addition to other benefits authorized under the
19 health benefit plan, a health benefit plan shall permit an enrollee
20 who selects an obstetrician or gynecologist under Section 1451.255
21 to have direct access to the health care services of that selected
22 physician without:

- 23 (1) a referral from the enrollee's primary care
24 physician; or
- 25 (2) prior authorization or precertification from the
26 plan issuer.

27 (c) A health benefit plan may not impose a copayment or
28 deductible for direct access to health care services as required by
29 this section unless the same copayment or deductible is imposed for
30 access to other health care services provided under the plan.

31 (d) This section does not affect the authority of a health
32 benefit plan issuer to require an obstetrician or gynecologist
33 selected by an enrollee under Section 1451.255 to forward
34 information concerning the medical care of the enrollee to the
35 enrollee's primary care physician. (V.T.I.C. Art. 21.53D, Secs.
36 4(a), (b), (c), (d) (part), as added Acts 75th Leg., R.S., Ch. 912.)

1 Source Law

2 Sec. 4. (a) In addition to other benefits
3 authorized by the plan, each health benefit plan shall
4 permit a woman who designates an obstetrician or
5 gynecologist as provided under Section 3 of this
6 article direct access to the health care services of
7 the designated obstetrician or gynecologist without a
8 referral by the woman's primary care physician or prior
9 authorization or precertification from a health
10 benefit plan.

11 (b) The access to health care services required
12 under this article includes, but is not limited to:

- 13 (1) one well-woman examination per year;
14 (2) care related to pregnancy;
15 (3) care for all active gynecological
16 conditions; and
17 (4) diagnosis, treatment, and referral for
18 any disease or condition within the scope of the
19 professional practice of a properly credentialed
20 obstetrician or gynecologist.

21 (c) A health benefit plan may not impose a
22 copayment or deductible for direct access to the
23 health care services of an obstetrician or
24 gynecologist under this section unless such an
25 additional cost is imposed for access to other health
26 care services provided under the plan.

27 (d) This section does not affect the authority
28 of a health benefit plan to require the designated
29 obstetrician or gynecologist to forward information
30 concerning the medical care of the patient to the
31 primary care physician. . . .

32 Revisor's Note

33 Section 4(b), V.T.I.C. Article 21.53D, as added
34 by Chapter 912, Acts of the 75th Legislature, Regular
35 Session, 1997, refers to access that "includes, but is
36 not limited to" access to certain services. The
37 revised law omits "but is not limited to" as
38 unnecessary because Section 311.005(13), Government
39 Code (Code Construction Act), and Section 312.011(19),
40 Government Code, provide that "includes" and
41 "including" are terms of enlargement and not of
42 limitation and do not create a presumption that
43 components not expressed are excluded. Those
44 provisions apply to the revised law.

45 Revised Law

46 Sec. 1451.257. AVAILABILITY OF PROVIDERS. To ensure
47 access to services that are within the scope of the professional
48 specialty practice of a properly credentialed obstetrician or
49 gynecologist, a health benefit plan shall include in the

1 classification of persons authorized to provide medical services
2 under the plan a sufficient number of properly credentialed
3 obstetricians and gynecologists. (V.T.I.C. Art. 21.53D, Sec.
4 3(b), as added Acts 75th Leg., R.S., Ch. 912.)

5 Source Law

6 (b) The plan shall include in the classification
7 of persons authorized to provide medical services
8 under the plan a number of properly credentialed
9 obstetricians and gynecologists sufficient to ensure
10 access to the services that fall within the scope of
11 that credential.

12 Revised Law

13 Sec. 1451.258. NOTICE OF AVAILABLE PROVIDERS. (a) A
14 health benefit plan issuer shall provide to each person covered
15 under the plan a timely written notice of the choices of the types
16 of physician providers available for the direct access required
17 under this subchapter.

18 (b) The notice must be stated in clear and accurate
19 language. (V.T.I.C. Art. 21.53D, Sec. 5, as added Acts 75th Leg.,
20 R.S., Ch. 912.)

21 Source Law

22 Sec. 5. Each health benefit plan shall provide
23 to persons covered by the plan a timely written notice
24 in clear and accurate language of the choices of types
25 of physician providers for the direct access to health
26 care services required by this article.

27 Revised Law

28 Sec. 1451.259. LIMITS ON PHYSICIAN SANCTIONS. (a) A
29 health benefit plan may not sanction or terminate a primary care
30 physician because of female enrollees' access to participating
31 obstetricians and gynecologists under this subchapter.

32 (b) A health benefit plan may not impose a financial or
33 other penalty on an obstetrician or gynecologist selected under
34 Section 1451.255, or on the enrollee who selected the physician,
35 because the selected physician failed to provide to the enrollee's
36 primary care physician information concerning the medical care of
37 the enrollee if the selected physician made a reasonable good faith
38 effort to forward the information. (V.T.I.C. Art. 21.53D, Secs.

1 4(d) (part), (f), as added Acts 75th Leg., R.S., Ch. 912.)

2 Source Law

3 (d) . . . [to require the designated
4 obstetrician or gynecologist to forward information
5 concerning the medical care of the patient to the
6 primary care physician.] Failure to provide this
7 information may not result in any penalty, financial
8 or otherwise, being imposed upon the obstetrician or
9 gynecologist or the patient by the health benefit plan
10 if the obstetrician or gynecologist has made a
11 reasonable and good-faith effort to provide the
12 information to the primary care physician.

13 (f) A health benefit plan shall not sanction or
14 terminate primary care physicians as a result of
15 female enrollees' access to participating
16 obstetricians and gynecologists under this section.

17 Revised Law

18 Sec. 1451.260. ADMINISTRATIVE PENALTY. An entity that
19 operates a health benefit plan in violation of this subchapter is
20 subject to an administrative penalty as provided by Chapter 84.
21 (V.T.I.C. Art. 21.53D, Sec. 7, as added Acts 75th Leg., R.S., Ch.
22 912.)

23 Source Law

24 Sec. 7. An insurance company, health maintenance
25 organization, or other entity that operates a health
26 benefit plan in violation of this article is subject to
27 an administrative penalty as provided by Article 1.10E
28 of this code.

29 Revisor's Note

30 Section 7, V.T.I.C. Article 21.53D, as added by
31 Chapter 912, Acts of the 75th Legislature, Regular
32 Session, 1997, refers to an "insurance company, health
33 maintenance organization, or other entity that
34 operates a health benefit plan." The revised law omits
35 as unnecessary the references to "insurance company"
36 and "health maintenance organization" because each is
37 included within the meaning of "entity."

38 [Sections 1451.261-1451.300 reserved for expansion]

39 SUBCHAPTER G. ACCESS TO DIETITIAN SERVICES

40 Revised Law

41 Sec. 1451.301. APPLICABILITY OF GENERAL PROVISIONS OF OTHER
42 LAW. The provisions of Chapter 1201, including provisions

1 relating to the applicability, purpose, and enforcement of that
2 chapter, the construction of policies under that chapter,
3 rulemaking under that chapter, and definitions of terms applicable
4 in that chapter, apply to this subchapter. (New.)

5 Revisor's Note

6 Section (H), V.T.I.C. Article 3.70-2, was enacted
7 as part of an amendment to Chapter 397, Acts of the
8 54th Legislature, Regular Session, 1955, published as
9 V.T.I.C. Articles 3.70-1, 3.70-2, 3.70-3, 3.70-3A,
10 3.70-3B, 3.70-4, 3.70-5, 3.70-6, 3.70-7, 3.70-8,
11 3.70-9, 3.70-10, and 3.70-11. The majority of those
12 articles, which include general provisions applicable
13 to Section (H), V.T.I.C. Article 3.70-2, are revised
14 in this code as Chapter 1201. Section 1451.301 is added
15 to indicate the applicability of those general
16 provisions to this subchapter. For the convenience of
17 the reader, the revised law includes general
18 descriptions of some of the applicable provisions of
19 Chapter 1201.

20 Revised Law

21 Sec. 1451.302. DIETITIAN SERVICES. An individual or group
22 accident and health insurance policy delivered or issued for
23 delivery in this state may not:

24 (1) exclude or deny coverage for services performed
25 by:

26 (A) a dietitian; or

27 (B) a provisionally licensed dietitian acting
28 under the supervision of a dietitian; or

29 (2) refuse payment or reimbursement for charges for
30 services described by Subdivision (1) if the services:

31 (A) are in the scope of the dietitian's license;

32 (B) are related to an injury or illness the
33 policy covers if the services are scheduled in the policy; and

34 (C) are provided under a professional

1 recommendation of a physician whose treatment or examination for
2 the injury or illness would be covered by the policy and would be
3 payable or reimbursable under the policy. (V.T.I.C. Art. 3.70-2,
4 Sec. (H), as amended Acts 70th Leg., R.S., Ch. 875, Sec. 2.)

5 Source Law

6 (H) An individual or group policy of accident or
7 sickness insurance delivered or issued for delivery in
8 this state may not exclude or deny coverage for
9 services performed by a licensed dietitian, or by a
10 provisional licensed dietitian under the supervision
11 of a licensed dietitian, and may not refuse payment and
12 reimbursement for charges for those services if the
13 services are:

14 (1) within the scope of the licensed
15 dietitian's license;

16 (2) related to an injury or illness
17 covered by the policy if those services are scheduled
18 in the policy; and

19 (3) provided under a professional
20 recommendation by a doctor of medicine or doctor of
21 osteopathy whose treatment or examination for the
22 injury or illness would be covered by the policy and
23 would be payable or reimbursable under the policy.

24 [Sections 1451.303-1451.350 reserved for expansion]

25 SUBCHAPTER H. DISABILITY CERTIFIED BY PODIATRIST

26 Revised Law

27 Sec. 1451.351. LOSS OF INCOME BENEFITS FOR DISABILITY
28 TREATABLE BY PODIATRIST. (a) This section applies only to an
29 insurance policy delivered, issued for delivery, or renewed in this
30 state that provides benefits covering loss of income as a result of
31 an acute temporary disability caused by sickness or injury.

32 (b) An insurance policy may not deny payment of benefits
33 described by Subsection (a) solely because the disability is
34 certified or attested to by a podiatrist if the disability is caused
35 by a sickness or injury that may be treated within the scope of the
36 podiatrist's license. (V.T.I.C. Art. 21.52A.)

37 Source Law

38 Art. 21.52A. An insurance policy that is
39 delivered, issued for delivery, or renewed in this
40 state and that provides benefits covering loss of
41 income based on an acute and temporary disability
42 caused by sickness or injury may not deny payment of
43 those benefits on the ground that the acute and
44 temporary disability is certified or attested to by a
45 podiatrist licensed by the Texas State Board of
46 Podiatric Medical Examiners if the acute and temporary
47 disability is caused by a sickness or injury that may

1 be treated by acts performed by a licensed podiatrist
2 under the scope of that license.

3 [Sections 1451.352-1451.400 reserved for expansion]

4 SUBCHAPTER I. USE OF OSTEOPATHIC HOSPITAL

5 Revised Law

6 Sec. 1451.401. CONTRACT WITH OSTEOPATHIC HOSPITAL. A
7 health maintenance organization or preferred provider benefit plan
8 issuer that contracts with a hospital to provide services to
9 covered individuals may not refuse to contract with an osteopathic
10 hospital solely because the hospital is an osteopathic hospital.
11 (V.T.I.C. Art. 21.53B, Sec. (a).)

12 Source Law

13 Art. 21.53B. (a) A health maintenance or
14 preferred provider organization that contracts with a
15 hospital to provide services to covered individuals
16 may not refuse to contract with a particular hospital
17 solely because that hospital is an osteopathic
18 hospital.

19 Revisor's Note

20 Section (a), V.T.I.C. Article 21.53B, refers to a
21 "preferred provider organization." The revised law
22 substitutes "preferred provider benefit plan issuer"
23 for "preferred provider organization" for the reason
24 stated in Revisor's Note (2) to Section 1451.126.

25 Revised Law

26 Sec. 1451.402. SERVICES AT OSTEOPATHIC HOSPITAL. A health
27 maintenance organization or preferred provider benefit plan issuer
28 that provides benefits for inpatient or outpatient services
29 provided by an allopathic hospital shall seek to provide benefits
30 for similar services provided by an osteopathic hospital if there
31 is an osteopathic hospital within the service area of the health
32 maintenance organization or preferred provider benefit plan issuer
33 that will provide the services at a substantially similar cost.
34 (V.T.I.C. Art. 21.53B, Sec. (b).)

35 Source Law

36 (b) A health maintenance or preferred provider
37 organization that provides benefits for inpatient or
38 outpatient services provided by allopathic hospitals
39 shall seek to provide benefits for similar services

1 provided by an osteopathic hospital if there is an
2 osteopathic hospital within the service area of the
3 health maintenance or preferred provider organization
4 that will provide those services at substantially
5 similar cost.

6 Revisor's Note

7 Section (b), V.T.I.C. Article 21.53B, refers to a
8 "preferred provider organization." The revised law
9 substitutes "preferred provider benefit plan issuer"
10 for "preferred provider organization" for the reason
11 stated in Revisor's Note (2) to Section 1451.126.

12 Revised Law

13 Sec. 1451.403. REQUEST FOR ACTION OF COMMISSIONER. An
14 aggrieved party may request that the commissioner conduct an
15 investigation, review, hearing, or other proceeding to determine
16 compliance with this subchapter. (V.T.I.C. Art. 21.53B, Sec. (c)
17 (part).)

18 Source Law

19 (c) . . . An aggrieved party may ask the
20 commissioner to conduct any investigation, review,
21 hearing, or other proceeding to determine compliance
22 with this section. . . .

23 Revised Law

24 Sec. 1451.404. ENFORCEMENT. The commissioner shall take
25 all reasonable actions to ensure compliance with this subchapter,
26 including issuing orders and assessing penalties. (V.T.I.C.
27 Art. 21.53B, Sec. (c) (part).)

28 Source Law

29 (c) The commissioner shall have all necessary
30 authority to enforce this section. . . . The
31 commissioner shall take all reasonable steps,
32 including the issuance of orders and the assessment of
33 penalties, to ensure compliance with this section.

34 Revisor's Note

35 Section (c), V.T.I.C. Article 21.53B, provides
36 that "[t]he commissioner shall have all necessary
37 authority to enforce this section." The revised law
38 omits the quoted language as unnecessary because it is
39 redundant. An accepted principle of statutory
40 construction provides that a statute that imposes a

1 duty on a public official confers on the official the
2 authority to carry out the duty. Section (c), V.T.I.C.
3 Article 21.53B, imposes a duty on the commissioner to
4 "take all reasonable steps . . . to ensure compliance
5 with this [article]," and so confers all necessary
6 authority to enforce the article.

7 CHAPTER 1452. PHYSICIAN AND PROVIDER CREDENTIALS

8 SUBCHAPTER A. CREDENTIALING OF PHYSICIANS AND PROVIDERS

9 BY HEALTH MAINTENANCE ORGANIZATION

10 Sec. 1452.001. APPLICABILITY OF CERTAIN DEFINITIONS 1117
11 Sec. 1452.002. VERIFICATION OF PHYSICIAN'S LICENSE
12 OR CERTIFICATE 1118
13 Sec. 1452.003. SITE VISIT FOR INITIAL CREDENTIALING 1118
14 Sec. 1452.004. LIMITATION ON COMMISSIONER'S AUTHORITY 1119
15 Sec. 1452.005. SITE VISIT FOR CAUSE NOT PRECLUDED. 1119
16 Sec. 1452.006. RULES RELATED TO SELECTION OF PHYSICIANS
17 AND PROVIDERS BY HEALTH MAINTENANCE
18 ORGANIZATION. 1120

19 [Sections 1452.007-1452.050 reserved for expansion]

20 SUBCHAPTER B. STANDARDIZED FORMS

21 Sec. 1452.051. DEFINITION 1120
22 Sec. 1452.052. STANDARDIZED FORM FOR VERIFICATION
23 OF PHYSICIAN CREDENTIALS 1121

24 CHAPTER 1452. PHYSICIAN AND PROVIDER CREDENTIALS

25 SUBCHAPTER A. CREDENTIALING OF PHYSICIANS AND PROVIDERS

26 BY HEALTH MAINTENANCE ORGANIZATION

27 Revised Law

28 Sec. 1452.001. APPLICABILITY OF CERTAIN DEFINITIONS. In
29 this subchapter, a term defined by Section 843.002 has the meaning
30 assigned by that section. (V.T.I.C. Art. 20A.01B, as added Acts
31 77th Leg., R.S., Ch. 1419.)

32 Source Law

33 Art. 20A.01B. In this Act, terms defined by
34 Section 843.002, Insurance Code, have the meanings
35 assigned by that section.

1 Revised Law

2 Sec. 1452.002. VERIFICATION OF PHYSICIAN'S LICENSE OR
3 CERTIFICATE. The commissioner shall require a health maintenance
4 organization to verify that a physician's license to practice
5 medicine and any other certificate the physician is required to
6 hold, including a certificate issued by the Department of Public
7 Safety or the federal Drug Enforcement Administration or a
8 certificate issued under the Medicare program, is valid as of the
9 date of:

- 10 (1) initial credentialing of the physician; and
11 (2) each recredentialing. (V.T.I.C. Art. 20A.39,
12 Sec. (b).)

13 Source Law

14 (b) The commissioner shall require a health
15 maintenance organization to verify that a physician's
16 license to practice medicine and any other certificate
17 the physician is required to hold, including a
18 certificate issued by the Department of Public Safety
19 of the State of Texas or the federal Drug Enforcement
20 Agency or a certificate issued under the Medicare
21 program, is valid as of the date of initial
22 credentialing and on the date of each recredentialing.

23 Revisor's Note

24 Section (b), V.T.I.C. Article 20A.39, refers to
25 the federal Drug Enforcement Agency. The correct name
26 for that entity is the Drug Enforcement
27 Administration. The revised law is drafted
28 accordingly.

29 Revised Law

30 Sec. 1452.003. SITE VISIT FOR INITIAL CREDENTIALING. (a)
31 The commissioner shall require a health maintenance organization
32 that conducts a site visit for the purpose of initial credentialing
33 of a physician or provider to evaluate during the visit a site's
34 accessibility, appearance, space, medical or dental recordkeeping
35 practices, availability of appointments, and confidentiality
36 procedures.

37 (b) The commissioner may not require the health maintenance
38 organization to evaluate the appropriateness of equipment during

1 the site visit. (V.T.I.C. Art. 20A.39, Sec. (c).)

2 Source Law

3 (c) The commissioner shall require a health
4 maintenance organization that conducts a site visit
5 for the purpose of initial credentialing to evaluate
6 during the visit a site's accessibility, appearance,
7 space, medical or dental recordkeeping practices,
8 availability of appointments, and confidentiality
9 procedures. The commissioner may not require the
10 health maintenance organization to evaluate the
11 appropriateness of equipment during the site visit.

12 Revised Law

13 Sec. 1452.004. LIMITATION ON COMMISSIONER'S AUTHORITY. The
14 commissioner may not require a health maintenance organization to:

15 (1) formally recredential a physician or provider more
16 frequently than once in any three-year period;

17 (2) verify the validity of a license or certificate
18 held by a physician as of a date other than the date of initial
19 credentialing or recredentialing of the physician;

20 (3) use clinical personnel to perform a site visit for
21 initial credentialing of a physician or provider unless clinical
22 review is needed during the site visit; or

23 (4) require a site visit be performed for the purpose
24 of recredentialing of a physician or provider. (V.T.I.C.
25 Art. 20A.39, Sec. (d).)

26 Source Law

27 (d) The commissioner may not require that a
28 health maintenance organization:

29 (1) formally recredential physicians or
30 providers more frequently than once in any three-year
31 period;

32 (2) verify the validity of a license or
33 certificate held by a physician other than as of the
34 date of initial credentialing or recredentialing of
35 the physician;

36 (3) use clinical personnel to perform a
37 site visit for initial credentialing of a physician or
38 provider unless clinical review is needed during the
39 site visit; or

40 (4) require a site visit be performed for
41 recredentialing of a physician or provider.

42 Revised Law

43 Sec. 1452.005. SITE VISIT FOR CAUSE NOT PRECLUDED. This
44 subchapter does not preclude a health maintenance organization from
45 conducting a site visit of a physician or provider at any time for

1 cause, including a complaint made by a member or another external
2 complaint made to the health maintenance organization. (V.T.I.C.
3 Art. 20A.39, Sec. (e).)

4 Source Law

5 (e) This section does not preclude a health
6 maintenance organization from performing a site visit
7 of a physician or provider at any time for cause,
8 including a complaint made by a member or another
9 external complaint made to the health maintenance
10 organization.

11 Revised Law

12 Sec. 1452.006. RULES RELATED TO SELECTION OF PHYSICIANS AND
13 PROVIDERS BY HEALTH MAINTENANCE ORGANIZATION. A rule adopted by
14 the commissioner under Section 843.102 that relates to
15 implementation and maintenance by a health maintenance
16 organization of a process for selecting and retaining affiliated
17 physicians and providers must comply with:

18 (1) this subchapter; and

19 (2) standards adopted by the National Committee for
20 Quality Assurance, to the extent those standards do not conflict
21 with other laws of this state. (V.T.I.C. Art. 20A.39, Sec. (a).)

22 Source Law

23 Art. 20A.39. (a) Rules adopted by the
24 commissioner under Section 37 of this Act that relate
25 to implementation and maintenance by a health
26 maintenance organization of a process for selecting
27 and retaining affiliated physicians and providers must
28 comply with:

29 (1) this section; and

30 (2) standards promulgated by the National
31 Committee for Quality Assurance, to the extent those
32 standards do not conflict with other laws of this
33 state.

34 [Sections 1452.007-1452.050 reserved for expansion]

35 SUBCHAPTER B. STANDARDIZED FORMS

36 Revised Law

37 Sec. 1452.051. DEFINITION. In this subchapter,
38 "physician" means an individual licensed to practice medicine in
39 this state. (V.T.I.C. Art. 21.58D, Sec. 1.)

40 Source Law

41 Art. 21.58D

42 Sec. 1. In this article, "physician" means an

1 individual licensed to practice medicine in this
2 state.

3 Revised Law

4 Sec. 1452.052. STANDARDIZED FORM FOR VERIFICATION OF
5 PHYSICIAN CREDENTIALS. (a) The commissioner by rule shall:

6 (1) prescribe a standardized form for the verification
7 of a physician's credentials; and

8 (2) require a public or private hospital, a health
9 maintenance organization operating under Chapter 843, or the issuer
10 of a preferred provider benefit plan under Chapter 1301 to use the
11 form for verification of physician credentials.

12 (b) In prescribing a form under this section, the
13 commissioner shall consider any credentialing application form
14 that is widely used in this state. (V.T.I.C. Art. 21.58D, Sec. 2.)

15 Source Law

16 Sec. 2. (a) The commissioner by rule shall:

17 (1) adopt a standardized form for the
18 verification of the credentials of a physician; and

19 (2) require that a public or private
20 hospital, a health maintenance organization operating
21 under the Texas Health Maintenance Organization Act
22 (Chapter 20A, Vernon's Texas Insurance Code), or a
23 preferred provider organization operating under
24 Article 3.70-3C, Insurance Code, as added by Chapter
25 1024, Acts of the 75th Legislature, Regular Session,
26 1997, use the form for verification of credentials.

27 (b) In adopting a form under Subsection (a) of
28 this section, the commissioner shall consider any
29 credentialing application form that is widely used in
30 this state.

31 Revisor's Note

32 Section 2(a)(2), V.T.I.C. Article 21.58D, refers
33 to a "preferred provider organization operating under
34 Article 3.70-3C, Insurance Code." The revised law
35 substitutes "the issuer of a preferred provider
36 benefit plan under Chapter 1301" for consistency with
37 terminology used in V.T.I.C. Article 3.70-3C, revised
38 as Chapter 1301 of this code.

39 CHAPTER 1453. DISCLOSURE OF REIMBURSEMENT GUIDELINES
40 UNDER MANAGED CARE PLAN

41 Sec. 1453.001. DEFINITIONS 1122

42 Sec. 1453.002. PROVISION OF INFORMATION REGARDING

1 REIMBURSEMENT GUIDELINES 1124

2 Sec. 1453.003. RULES 1126

3 CHAPTER 1453. DISCLOSURE OF REIMBURSEMENT GUIDELINES

4 UNDER MANAGED CARE PLAN

5 Revised Law

6 Sec. 1453.001. DEFINITIONS. In this chapter:

7 (1) "Health care provider" means:

8 (A) a hospital, emergency clinic, outpatient
9 clinic, or other facility providing health care services; or

10 (B) an individual who is licensed in this state
11 to provide health care services.

12 (2) "Managed care entity" means:

13 (A) a health maintenance organization;

14 (B) a preferred provider benefit plan issuer;

15 (C) an approved nonprofit health corporation
16 that holds a certificate of authority under Chapter 844; or

17 (D) another entity that offers a managed care
18 plan, including:

19 (i) an insurance company;

20 (ii) a group hospital service corporation
21 operating under Chapter 842;

22 (iii) a fraternal benefit society operating
23 under Chapter 885;

24 (iv) a stipulated premium company operating
25 under Chapter 884;

26 (v) a multiple employer welfare arrangement
27 that holds a certificate of authority under Chapter 846; and

28 (vi) an entity not authorized under this
29 code or another insurance law of this state that contracts directly
30 for health care services on a risk-sharing basis, including a
31 capitation basis.

32 (3) "Managed care plan" means a health benefit plan:

33 (A) under which health care services are provided
34 through contracts with health care providers to individuals

1 enrolled in or insured under the plan; and

2 (B) that provides financial incentives to
3 individuals enrolled in or insured under the plan to use health care
4 providers participating in the plan and procedures covered by the
5 plan. (V.T.I.C. Art. 21.60, Sec. 1.)

6 Source Law

7 Art. 21.60

8 Sec. 1. In this article:

9 (1) "Health care provider" means:

10 (A) a hospital, emergency clinic,
11 outpatient clinic, or other facility providing health
12 care; or

13 (B) an individual who is licensed in
14 this state to provide health care.

15 (2) "Managed care entity" means a health
16 maintenance organization, a preferred provider
17 organization, an approved nonprofit health
18 corporation that holds a certificate of authority
19 issued by the commissioner under Article 21.52F of
20 this code, and any other entity that offers a managed
21 care plan, including:

22 (A) an insurance company;

23 (B) a group hospital service
24 corporation operating under Chapter 20 of this code;

25 (C) a fraternal benefit society
26 operating under Chapter 10 of this code;

27 (D) a stipulated premium insurance
28 company operating under Chapter 22 of this code;

29 (E) a multiple employer welfare
30 arrangement that holds a certificate of authority
31 under Article 3.95-2 of this code; or

32 (F) any entity not licensed under
33 this code or another insurance law of this state that
34 contracts directly for health care services on a
35 risk-sharing basis, including an entity that contracts
36 for health care services under a capitation method.

37 (3) "Managed care plan" means a health
38 benefit plan:

39 (A) under which health care services
40 are provided through contracts with health care
41 professionals or health care facilities to persons
42 enrolled in or insured under the plan; and

43 (B) that provides financial
44 incentives to persons enrolled in or insured under the
45 plan to use the participating practitioners,
46 participating health care facilities, and procedures
47 covered by the plan.

48 Revisor's Note

49 (1) Section 1(2), V.T.I.C. Article 21.60,
50 states that a "managed care entity" means "a health
51 maintenance organization, a preferred provider
52 organization, an approved nonprofit health
53 corporation . . . , and any other entity that offers a
54 managed care plan." The revised law substitutes

1 "preferred provider benefit plan issuer" for
2 "preferred provider organization" for clarity and
3 consistency with terminology used in this code. In
4 context, it is apparent that the provision is intended
5 to apply to an entity that issues a preferred provider
6 benefit plan.

7 (2) Section 1(2), V.T.I.C. Article 21.60,
8 refers to an approved nonprofit health corporation
9 that holds a certificate of authority "issued by the
10 commissioner under Article 21.52F of this code." The
11 revised law omits the reference to the commissioner
12 issuing the certificate of authority as unnecessary
13 because Article 21.52F, revised as Chapter 844 of this
14 code, requires the commissioner to issue the
15 certificate of authority.

16 (3) Section 1(2)(F), V.T.I.C. Article 21.60,
17 refers to a managed care plan offered by an entity that
18 is not "licensed" under the Insurance Code or another
19 insurance law of this state. The revised law
20 substitutes "authorized" for "licensed" for
21 consistency with terminology used throughout this
22 code.

23 (4) Section 1(3), V.T.I.C. Article 21.60,
24 refers to "health care professionals or health care
25 facilities" and "practitioners [and] health care
26 facilities." The revised law substitutes "health care
27 providers" for the quoted phrases because that is the
28 defined term used in this chapter and, in context, the
29 substance of the definition of that term is synonymous
30 with the meaning of the quoted phrases.

31 Revised Law

32 Sec. 1453.002. PROVISION OF INFORMATION REGARDING
33 REIMBURSEMENT GUIDELINES. (a) On the written request of an
34 out-of-network health care provider, a managed care entity shall

1 furnish to the provider a written description of the factors
2 considered by the entity in determining the amount of reimbursement
3 the provider may receive for goods or services provided to an
4 individual enrolled in or insured under the entity's managed care
5 plan.

6 (b) This section does not require a managed care entity to
7 disclose proprietary information that is prohibited from
8 disclosure by a contract between the entity and a vendor that
9 supplies payment or statistical data to the entity.

10 (c) A contract between a managed care entity and a vendor
11 that supplies payment or statistical data to the entity may not
12 prohibit the entity from disclosing under this section:

13 (1) the name of the vendor; or

14 (2) the methodology and origin of information used to
15 determine the amount of reimbursement.

16 (d) A managed care entity that denies a request for
17 information described by Subsection (b) shall send a copy of the
18 request and the information requested to the department for review.

19 (V.T.I.C. Art. 21.60, Sec. 2.)

20 Source Law

21 Sec. 2. (a) On the written request of an
22 out-of-network health care provider, a managed care
23 entity shall provide the provider with a written
24 description of the factors considered by the managed
25 care entity in determining the amount of reimbursement
26 that the out-of-network provider may receive for goods
27 or services provided to a person enrolled in or insured
28 under the entity's managed care plan.

29 (b) This article does not require a managed care
30 entity to disclose proprietary information that a
31 contract between the managed care entity and a vendor
32 who supplies payment or statistical data to the
33 managed care entity prohibits from disclosure.

34 (c) A contract between the managed care entity
35 and a vendor who supplies payment or statistical data
36 to the managed care entity may not prohibit the managed
37 care entity from disclosing under this section:

38 (1) the name of the vendor; or

39 (2) the methodology and origin of
40 information used to compute the amount of
41 reimbursement.

42 (d) A managed care entity that denies a request
43 for information under Subsection (b) of this section
44 shall send a copy of the request and the information
45 requested to the department for review.

1 Revised Law

2 Sec. 1453.003. RULES. The commissioner shall adopt rules
3 as necessary to implement this chapter. (V.T.I.C. Art. 21.60, Sec.
4 3.)

5 Source Law

6 Sec. 3. The commissioner shall adopt rules as
7 necessary to implement this article.

8 CHAPTER 1454. EQUAL HEALTH CARE FOR WOMEN

9 SUBCHAPTER A. GENERAL PROVISIONS

10 Sec. 1454.001. DEFINITIONS 1127

11 Sec. 1454.002. APPLICABILITY OF CHAPTER 1127

12 [Sections 1454.003-1454.050 reserved for expansion]

13 SUBCHAPTER B. REIMBURSEMENT FOR HEALTH CARE SERVICES

14 Sec. 1454.051. EQUAL REIMBURSEMENT REQUIRED. 1129

15 Sec. 1454.052. REIMBURSEMENT FOR ABORTION NOT REQUIRED . . . 1129

16 [Sections 1454.053-1454.100 reserved for expansion]

17 SUBCHAPTER C. ENFORCEMENT

18 Sec. 1454.101. SANCTIONS AUTHORIZED 1130

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1 CHAPTER 1454. EQUAL HEALTH CARE FOR WOMEN

2 SUBCHAPTER A. GENERAL PROVISIONS

3 Revised Law

4 Sec. 1454.001. DEFINITIONS. In this chapter:

5 (1) "Health care provider" means a home health aide,
6 hospital, nurse practitioner, nurse midwife, outpatient care
7 center, physician assistant, registered nurse, or surgery center.

8 (2) "Physician" has the meaning assigned by Section
9 151.002, Occupations Code. (V.T.I.C. Art. 21.53N, Sec. 1.)

10 Source Law

11 Art. 21.53N

12 Sec. 1. In this article:

13 (1) "Physician" means a person licensed by
14 the Texas State Board of Medical Examiners to practice
15 medicine and surgery in this state.

16 (2) "Provider" means a hospital, nurse
17 practitioner, registered nurse, physician assistant,
18 home health aide, nurse midwife, surgery center, or
19 other outpatient care center.

20 Revisor's Note

21 Section 1, V.T.I.C. Article 21.53N, defines
22 "provider" by listing various health care providers.
23 For consistency with this code and other codes and
24 because "health care provider" more accurately
25 describes the persons listed in the definition of
26 "provider," the revised law substitutes "health care
27 provider" for "provider." In addition, Section 1,
28 V.T.I.C. Article 21.53N, defines "physician" in a
29 manner that is substantively identical to Section
30 151.002, Occupations Code. For consistency, the
31 revised law therefore substitutes a cross-reference to
32 that section of the Occupations Code for the
33 definition provided by V.T.I.C. Article 21.53N.

34 Revised Law

35 Sec. 1454.002. APPLICABILITY OF CHAPTER. This chapter
36 applies only to a health benefit plan that provides benefits for
37 medical or surgical expenses incurred as a result of a health
38 condition, accident, or sickness, including an individual, group,

1 blanket, or franchise insurance policy or insurance agreement, a
2 group hospital service contract, or an individual or group evidence
3 of coverage or similar coverage document that is offered by:

4 (1) an insurance company;

5 (2) a group hospital service corporation operating
6 under Chapter 842;

7 (3) a fraternal benefit society operating under
8 Chapter 885;

9 (4) a stipulated premium company operating under
10 Chapter 884;

11 (5) a reciprocal exchange operating under Chapter 942;

12 (6) a health maintenance organization operating under
13 Chapter 843;

14 (7) a multiple employer welfare arrangement that holds
15 a certificate of authority under Chapter 846;

16 (8) an approved nonprofit health corporation that
17 holds a certificate of authority under Chapter 844; or

18 (9) a small employer health benefit plan written under
19 Chapter 1501. (V.T.I.C. Art. 21.53N, Sec. 2.)

20 Source Law

21 Sec. 2. This article applies only to a health
22 benefit plan that provides benefits for medical or
23 surgical expenses incurred as a result of a health
24 condition, accident, or sickness, including an
25 individual, group blanket, or franchise insurance
26 policy or insurance agreement, a group hospital
27 service contract, or an individual or group evidence
28 of coverage or similar coverage document that is
29 offered by:

30 (1) an insurance company;

31 (2) a group hospital service corporation
32 operating under Chapter 20 of this code;

33 (3) a fraternal benefit society operating
34 under Chapter 10 of this code;

35 (4) a stipulated premium insurance company
36 operating under Chapter 22 of this code;

37 (5) a reciprocal exchange operating under
38 Chapter 19 of this code;

39 (6) a health maintenance organization
40 operating under the Texas Health Maintenance
41 Organization Act (Chapter 20A, Vernon's Texas
42 Insurance Code);

43 (7) a multiple employer welfare
44 arrangement that holds a certificate of authority
45 under Article 3.95-2 of this code;

46 (8) an approved nonprofit health
47 corporation that holds a certificate of authority

1 under Article 21.52F of this code; or
2 (9) a small employer health benefit plan
3 written under Chapter 26 of this code.

4 [Sections 1454.003-1454.050 reserved for expansion]

5 SUBCHAPTER B. REIMBURSEMENT FOR HEALTH CARE SERVICES

6 Revised Law

7 Sec. 1454.051. EQUAL REIMBURSEMENT REQUIRED. A health
8 benefit plan issuer that reimburses a physician or health care
9 provider for reproductive health or oncology services provided to
10 women must reimburse the physician or provider in an amount at least
11 equal to the annual average compensation per hour or unit that would
12 be paid in the service area to a physician or provider for the same
13 medical, surgical, hospital, pharmaceutical, nursing, or other
14 similar resources used to provide the services if the resources
15 would be used to provide health services exclusively to men or to
16 the general population. (V.T.I.C. Art. 21.53N, Sec. 3.)

17 Source Law

18 Sec. 3. When reimbursing a physician or provider
19 for reproductive health and oncology services provided
20 to women, a health benefit plan must pay an amount not
21 less than the annual average compensation per hour or
22 unit as would be paid in the service area to a
23 physician or provider for the same medical, surgical,
24 hospital, pharmaceutical, nursing, or other similar
25 resources, as applicable, that would be used in
26 providing health services exclusively to men or to the
27 general population.

28 Revised Law

29 Sec. 1454.052. REIMBURSEMENT FOR ABORTION NOT REQUIRED.
30 This chapter does not require a health benefit plan issuer to
31 provide reimbursement for an abortion, as defined by the Family
32 Code, or for a service related to an abortion. (V.T.I.C.
33 Art. 21.53N, Sec. 6.)

34 Source Law

35 Sec. 6. This article does not require the issuer
36 of a health benefit plan to provide reimbursement for
37 an abortion as defined by the Family Code or related
38 services.

39 [Sections 1454.053-1454.100 reserved for expansion]

1 SUBCHAPTER C. ENFORCEMENT

2 Revised Law

3 Sec. 1454.101. SANCTIONS AUTHORIZED. The sanctions
4 authorized by Chapter 82 apply to a health benefit plan issuer that
5 violates this chapter. (V.T.I.C. Art. 21.53N, Sec. 4(a) (part).)

6 Source Law

7 Sec. 4. (a) A health benefit plan as described
8 by Section 2 of this article that is found to be in
9 violation of or failing to comply with this article is
10 subject to the sanctions authorized by Chapter 82 of
11 this code. . . .

12 Revisor's Note

13 Section 4(a), V.T.I.C. Article 21.53N, refers to
14 a health benefit plan that is found to be "in violation
15 of or failing to comply" with this chapter. The
16 revised law omits "failing to comply" as unnecessary
17 because a plan that violates this chapter fails to
18 comply with it.

19 Revised Law

20 Sec. 1454.102. CEASE AND DESIST PROCEDURES AND RESTITUTION
21 FOR ATTORNEY'S FEES AUTHORIZED. The commissioner may use the cease
22 and desist procedures authorized by Chapter 83 against a health
23 benefit plan issuer that violates this chapter. In accordance with
24 Chapter 83, the commissioner may order the health benefit plan
25 issuer to make complete restitution for the violation, which may
26 include restitution for the reasonable attorney's fees incurred by
27 a person making a complaint under this chapter. (V.T.I.C.
28 Art. 21.53N, Sec. 4(a) (part).)

29 Source Law

30 (a) . . . The commissioner may also use the
31 cease and desist procedures authorized by Chapter 83
32 of this code and, in accordance with the provisions of
33 that chapter, direct the plan to make complete
34 restitution, which may include reasonable attorney's
35 fees incurred by a person making a complaint under this
36 article. . . .

37 Revised Law

38 Sec. 1454.103. ADMINISTRATIVE PENALTIES AUTHORIZED. (a)
39 In addition to any sanctions authorized by this subchapter, the

1 commissioner may impose an administrative penalty in accordance
2 with Chapter 84 on a health benefit plan issuer that violates this
3 chapter.

4 (b) On a finding that a health benefit plan issuer knowingly
5 violated this chapter, the commissioner may impose in addition to
6 the administrative penalty authorized by Section 84.022 an
7 administrative penalty that does not exceed \$25,000. (V.T.I.C.
8 Art. 21.53N, Sec. 4(b).)

9 Source Law

10 (b) In addition to imposing the sanctions
11 authorized by Subsection (a) of this section, the
12 commissioner may impose an administrative penalty in
13 accordance with Chapter 84 of this code. Upon a
14 finding that the plan knowingly violated the
15 provisions of this article, the commissioner may
16 impose an administrative penalty not to exceed \$25,000
17 in addition to the penalty authorized by Section
18 84.022 of this code.

19 Revised Law

20 Sec. 1454.104. AMOUNT OF DAMAGES. Notwithstanding this
21 subchapter, in imposing a sanction or penalty for a violation of
22 this chapter, the commissioner may order a health benefit plan
23 issuer to pay the greater of complete or economic damages.
24 (V.T.I.C. Art. 21.53N, Sec. 4(a) (part).)

25 Source Law

26 (a) . . . Notwithstanding the provisions of
27 this section, the commissioner may order the greater
28 of complete or economic damages.

29 Revised Law

30 Sec. 1454.105. APPLICABILITY OF CERTAIN PROCEDURAL
31 REQUIREMENTS TO SANCTIONS OR ADMINISTRATIVE PENALTIES. Subchapter
32 C, Chapter 84, applies to the imposition of a sanction or
33 administrative penalty under this chapter. (V.T.I.C. Art. 21.53N,
34 Sec. 4(d).)

35 Source Law

36 (d) The procedural requirements established by
37 Subchapter C, Chapter 84 of this code, shall govern the
38 imposition of sanctions and administrative penalties
39 under this article.

1 Revised Law

2 Sec. 1454.106. INTERVENTION IN PROCEEDING. (a) In a
3 proceeding relating to the imposition by the commissioner of a
4 sanction or administrative penalty under this chapter, a person
5 affected by an order of the commissioner, including a physician or
6 health care provider, may intervene in the proceeding by filing a
7 notice of intervention with the commissioner. The commissioner
8 shall provide an affected person a reasonable period to intervene.

9 (b) At the time the commissioner notifies a health benefit
10 plan issuer of the issuer's opportunity for a hearing regarding an
11 alleged violation, the commissioner shall notify each affected
12 person of all relevant information regarding the hearing.

13 (c) A person who intervenes under this section has the
14 rights and powers of a party under Chapter 2001, Government Code.
15 (V.T.I.C. Art. 21.53N, Sec. 4(e).)

16 Source Law

17 (e) In any proceeding relating to the imposition
18 of a sanction or administrative penalty by the
19 commissioner under this article, any person affected
20 by an order of the commissioner, including a physician
21 or provider, is entitled to intervene in the
22 proceeding by filing with the commissioner a notice of
23 intervention. The commissioner shall afford an
24 affected person, including a physician or provider, a
25 reasonable period in which to intervene. At the time
26 the commissioner notifies the health benefit plan
27 about the plan's opportunity for a hearing regarding an
28 alleged violation, the commissioner shall provide a
29 notice to each affected person, including a physician
30 or provider, of all relevant information regarding the
31 hearing. An affected person, including a physician or
32 provider who intervenes under this subsection, has the
33 right and powers of a party under Chapter 2001,
34 Government Code.

35 Revised Law

36 Sec. 1454.107. TIME FOR COMMISSIONER'S DETERMINATION. Not
37 later than the 120th day after the date a complaint alleging a
38 violation of this chapter is filed with the department, the
39 commissioner shall determine whether the alleged violation
40 occurred and impose appropriate sanctions. (V.T.I.C. Art. 21.53N,
41 Sec. 4(c).)

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Source Law

(c) The commissioner shall make a determination of a violation of this article and impose the appropriate sanctions within 120 days of the date a complaint alleging a violation is filed.

Revised Law

Sec. 1454.108. FAILURE OF COMMISSIONER TO MAKE DETERMINATION BY ORDER; ACTION IN DISTRICT COURT. (a) If the commissioner fails to determine by order in the time prescribed by Section 1454.107 whether a violation alleged in a complaint filed under this chapter occurred, the person who filed the complaint may bring an action in district court for the violation.

(b) The action must be commenced not later than the first anniversary of the date by which the commissioner is required to make a determination under Section 1454.107.

(c) In an action filed under this section, a court may:

- (1) impose the sanctions authorized by this subchapter or similar sanctions;
- (2) assess an additional civil penalty of \$25,000 if the trier of fact finds the defendant knowingly violated this chapter; and
- (3) award a claimant who prevails in an action filed under this section reasonable attorney's fees and court costs, including reasonable and necessary expert witness fees.

(d) On a finding by the court that an action filed under this section was groundless and brought in bad faith or brought for the purpose of harassment, the court shall award the defendant reasonable and necessary attorney's fees. (V.T.I.C. Art. 21.53N, Secs. 5(b), (c), (d).)

Source Law

(b) If the commissioner fails to make a determination by order of a complaint within the time limit prescribed by Section 4(c) of this article, the person who initiated the complaint may bring an action in the district court for a violation of this article. The action must be commenced within 12 months after the date on which the time limit for the commissioner's determination expired.
(c) In a suit filed under Subsection (b) of this section, a court may impose the same or similar sanctions as provided under Section 4(a) of this

1 article, including an additional civil penalty of
2 \$25,000 if the trier of fact finds that the defendant
3 knowingly violated the provisions of this article. In
4 addition, if the claimant prevails in the action, the
5 court may award reasonable attorney's fees and court
6 costs, including any reasonable and necessary expert
7 witness fees.

8 (d) On a finding by the court that an action
9 under Subsection (b) of this section was groundless
10 and brought in bad faith or brought for the purpose of
11 harassment, the court shall award the defendant
12 reasonable and necessary attorney's fees.

13 Revised Law

14 Sec. 1454.109. APPEAL OF COMMISSIONER'S ORDER. (a) A
15 person affected by an order of the commissioner regarding a
16 violation of this chapter, including a person who intervenes under
17 Section 1454.106, may file an appeal in district court.

18 (b) The standard of review for an appeal filed under this
19 section is substantial evidence. (V.T.I.C. Art. 21.53N, Sec.
20 5(a).)

21 Source Law

22 Sec. 5. (a) A person, including a person who
23 intervenes under Section 4(e) of this article,
24 affected by an order of the commissioner regarding a
25 violation of this article may file an appeal in
26 district court. The standard of review under this
27 subsection is substantial evidence.

28 CHAPTER 1455. TELEMEDICINE AND TELEHEALTH

29 Sec. 1455.001. DEFINITIONS 1134
30 Sec. 1455.002. APPLICABILITY OF CHAPTER 1136
31 Sec. 1455.003. EXCEPTION. 1138
32 Sec. 1455.004. COVERAGE FOR TELEMEDICINE MEDICAL SERVICES
33 AND TELEHEALTH SERVICES 1139
34 Sec. 1455.005. RULES 1139

35 CHAPTER 1455. TELEMEDICINE AND TELEHEALTH

36 Revised Law

37 Sec. 1455.001. DEFINITIONS. In this chapter:

38 (1) "Health professional" means:

39 (A) a physician;

40 (B) an individual who is:

41 (i) licensed or certified in this state to
42 perform health care services; and

1 (ii) authorized to assist a physician in
2 providing telemedicine medical services that are delegated and
3 supervised by the physician; or

4 (C) a licensed or certified health professional
5 acting within the scope of the license or certification who does not
6 perform a telemedicine medical service.

7 (2) "Physician" means a person licensed to practice
8 medicine in this state under Subtitle B, Title 3, Occupations Code.

9 (3) "Telehealth service" and "telemedicine medical
10 service" have the meanings assigned by Section 57.042, Utilities
11 Code. (V.T.I.C. Art. 21.53F, Secs. 1(2), (3), (4), (5), as added
12 Acts 75th Leg., R.S., Ch. 880.)

13 Source Law

14 Art. 21.53F
15 Sec. 1. In this article:

- 16 (2) "Health professional" means:
17 (A) a physician;
18 (B) an individual who is:
19 (i) licensed or certified in
20 this state to perform health care services; and
21 (ii) authorized to assist a
22 physician in providing telemedicine medical services
23 that are delegated and supervised by the physician; or
24 (C) a licensed or certified health
25 professional acting within the scope of the license or
26 certification who does not perform a telemedicine
27 medical service.
28 (3) "Physician" means a person licensed to
29 practice medicine in this state under Subtitle B,
30 Title 3, Occupations Code.
31 (4) "Telehealth service" has the meaning
32 assigned by Section 57.042, Utilities Code.
33 (5) "Telemedicine medical service" has the
34 meaning assigned by Section 57.042, Utilities Code.

35 Revisor's Note

36 Section 1(1), V.T.I.C. Article 21.53F, as added
37 by Chapter 880, Acts of the 75th Legislature, Regular
38 Session, 1997, defines "health benefit plan." The
39 revised law omits the definition as unnecessary
40 because Section 2 of that article, revised as Sections
41 1455.002 and 1455.003, specifies the types of health
42 benefit plans to which this chapter applies, and thus
43 the defined term is not helpful to the reader. The

1 omitted law reads:

2 (1) "Health benefit plan" means
3 a plan described by Section 2 of this
4 article.

5 Revised Law

6 Sec. 1455.002. APPLICABILITY OF CHAPTER. This chapter
7 applies only to a health benefit plan that:

8 (1) provides benefits for medical or surgical expenses
9 incurred as a result of a health condition, accident, or sickness,
10 including:

11 (A) an individual, group, blanket, or franchise
12 insurance policy or insurance agreement, a group hospital service
13 contract, or an individual or group evidence of coverage that is
14 offered by:

15 (i) an insurance company;

16 (ii) a group hospital service corporation
17 operating under Chapter 842;

18 (iii) a fraternal benefit society operating
19 under Chapter 885;

20 (iv) a stipulated premium company operating
21 under Chapter 884; or

22 (v) a health maintenance organization
23 operating under Chapter 843; and

24 (B) to the extent permitted by the Employee
25 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et
26 seq.), a health benefit plan that is offered by:

27 (i) a multiple employer welfare arrangement
28 as defined by Section 3 of that Act; or

29 (ii) another analogous benefit
30 arrangement; or

31 (2) is offered by an approved nonprofit health
32 corporation that holds a certificate of authority under Chapter
33 844. (V.T.I.C. Art. 21.53F, Sec. 2(a), as added Acts 75th Leg.,
34 R.S., Ch. 880.)

1 Source Law

2 Sec. 2. (a) This article applies only to a
3 health benefit plan that:

4 (1) provides benefits for medical or
5 surgical expenses incurred as a result of a health
6 condition, accident, or sickness, including:

7 (A) an individual, group, blanket, or
8 franchise insurance policy or insurance agreement, a
9 group hospital service contract, or an individual or
10 group evidence of coverage that is offered by:

11 (i) an insurance company;

12 (ii) a group hospital service
13 corporation operating under Chapter 20 of this code;

14 (iii) a fraternal benefit
15 society operating under Chapter 10 of this code;

16 (iv) a stipulated premium
17 insurance company operating under Chapter 22 of this
18 code; or

19 (v) a health maintenance
20 organization operating under the Texas Health
21 Maintenance Organization Act (Chapter 20A, Vernon's
22 Texas Insurance Code); or

23 (B) to the extent permitted by the
24 Employee Retirement Income Security Act of 1974 (29
25 U.S.C. Section 1001 et seq.), a health benefit plan
26 that is offered by a multiple employer welfare
27 arrangement as defined by Section 3, Employee
28 Retirement Income Security Act of 1974 (29 U.S.C.
29 Section 1002) or another analogous benefit
30 arrangement; or

31 (2) is offered by an approved nonprofit
32 health corporation that is certified under Section
33 5.01(a), Medical Practice Act (Article 4495b, Vernon's
34 Texas Civil Statutes), and that holds a certificate of
35 authority issued by the commissioner under Article
36 21.52F of this code.

37 Revisor's Note

38 Section 2(a)(2), V.T.I.C. Article 21.53F, as
39 added by Chapter 880, Acts of the 75th Legislature,
40 Regular Session, 1997, refers to an approved nonprofit
41 health corporation that is "certified under Section
42 5.01(a), Medical Practice Act," and holds a
43 certificate of authority "issued by the commissioner
44 under Article 21.52F." The revised law omits the
45 reference to certification under Section 5.01(a),
46 Medical Practice Act (Article 4495b, Vernon's Texas
47 Civil Statutes), which was codified in 1999 in Chapter
48 162, Occupations Code, as unnecessary because V.T.I.C.
49 Article 21.52F, revised as Chapter 844 of this code,
50 requires a nonprofit corporation to be certified under
51 that provision as a condition of holding a certificate

1 of authority. The revised law also omits as
2 unnecessary the reference to the commissioner issuing
3 the certificate of authority because Chapter 844
4 requires the commissioner to issue the certificate of
5 authority.

6 Revised Law

7 Sec. 1455.003. EXCEPTION. This chapter does not apply to:

8 (1) a plan that provides coverage:

9 (A) only for a specified disease;

10 (B) only for accidental death or dismemberment;

11 (C) for wages or payments in lieu of wages for a
12 period during which an employee is absent from work because of
13 sickness or injury; or

14 (D) as a supplement to a liability insurance
15 policy;

16 (2) a small employer health benefit plan written under
17 Chapter 1501;

18 (3) a Medicare supplemental policy as defined by
19 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss);

20 (4) a workers' compensation insurance policy;

21 (5) medical payment insurance coverage provided under
22 a motor vehicle insurance policy; or

23 (6) a long-term care insurance policy, including a
24 nursing home fixed indemnity policy, unless the commissioner
25 determines that the policy provides benefit coverage so
26 comprehensive that the policy is a health benefit plan as described
27 by Section 1455.002. (V.T.I.C. Art. 21.53F, Sec. 2(b), as added
28 Acts 75th Leg., R.S., Ch. 880.)

29 Source Law

30 (b) This article does not apply to:

31 (1) a plan that provides coverage:

32 (A) only for a specified disease;

33 (B) only for accidental death or
34 dismemberment;

35 (C) for wages or payments in lieu of
36 wages for a period during which an employee is absent
37 from work because of sickness or injury; or

38 (D) as a supplement to liability

1 insurance;
2 (2) a small employer health benefit plan
3 written under Chapter 26 of this code;
4 (3) a Medicare supplemental policy as
5 defined by Section 1882(g)(1), Social Security Act (42
6 U.S.C. Section 1395ss);
7 (4) workers' compensation insurance
8 coverage;
9 (5) medical payment insurance issued as
10 part of a motor vehicle insurance policy; or
11 (6) a long-term care policy, including a
12 nursing home fixed indemnity policy, unless the
13 commissioner determines that the policy provides
14 benefit coverage so comprehensive that the policy is a
15 health benefit plan as described by Subsection (a) of
16 this section.

17 Revised Law

18 Sec. 1455.004. COVERAGE FOR TELEMEDICINE MEDICAL SERVICES
19 AND TELEHEALTH SERVICES. (a) A health benefit plan may not
20 exclude a telemedicine medical service or a telehealth service from
21 coverage under the plan solely because the service is not provided
22 through a face-to-face consultation.

23 (b) A health benefit plan may require a deductible, a
24 copayment, or coinsurance for a telemedicine medical service or a
25 telehealth service. The amount of the deductible, copayment, or
26 coinsurance may not exceed the amount of the deductible, copayment,
27 or coinsurance required for a comparable medical service provided
28 through a face-to-face consultation. (V.T.I.C. Art. 21.53F, Sec.
29 3, as added Acts 75th Leg., R.S., Ch. 880.)

30 Source Law

31 Sec. 3. (a) A health benefit plan may not
32 exclude a telemedicine medical service or a telehealth
33 service from coverage under the plan solely because
34 the service is not provided through a face-to-face
35 consultation.

36 (b) Benefits required under this article may be
37 made subject to a deductible, copayment, or
38 coinsurance requirement. A deductible, copayment, or
39 coinsurance applicable to a particular service
40 provided through telemedicine medical services or
41 telehealth services may not exceed the deductible,
42 copayment, or coinsurance required by the health
43 benefit plan for a comparable medical service provided
44 through a face-to-face consultation.

45 Revised Law

46 Sec. 1455.005. RULES. Subject to Section 107.004,
47 Occupations Code, the commissioner may adopt rules necessary to
48 implement this chapter. (V.T.I.C. Art. 21.53F, Sec. 6(a), as added

1 Acts 75th Leg., R.S., Ch. 880.)

2 Source Law

3 Sec. 6. (a) Subject to Subsection (b) of this
4 section, the commissioner may adopt rules as necessary
5 to implement this article.

6 [Chapters 1456-1500 reserved for expansion]

7 SUBTITLE G. HEALTH COVERAGE AVAILABILITY

8 CHAPTER 1501. HEALTH INSURANCE PORTABILITY AND AVAILABILITY ACT

9 SUBCHAPTER A. GENERAL PROVISIONS

10 Sec. 1501.001. SHORT TITLE 1145

11 Sec. 1501.002. DEFINITIONS 1145

12 Sec. 1501.003. APPLICABILITY: SMALL EMPLOYER HEALTH

13 BENEFIT PLANS 1156

14 Sec. 1501.004. APPLICABILITY: LARGE EMPLOYER HEALTH

15 BENEFIT PLANS 1156

16 Sec. 1501.005. EXCEPTION: CERTAIN INDIVIDUALLY

17 UNDERWRITTEN POLICIES 1157

18 Sec. 1501.006. CERTIFICATION 1157

19 Sec. 1501.007. AFFILIATES 1158

20 Sec. 1501.008. LATE ENROLLEES 1159

21 Sec. 1501.009. SCHOOL DISTRICT ELECTION 1162

22 Sec. 1501.010. GENERAL RULES 1162

23 Sec. 1501.011. DETERMINATION OF EMPLOYER STATUS FOR

24 CERTAIN EMPLOYERS 1163

25 [Sections 1501.012-1501.050 reserved for expansion]

26 SUBCHAPTER B. PURCHASING COOPERATIVES

27 Sec. 1501.051. DEFINITIONS 1164

28 Sec. 1501.052. TEXAS HEALTH BENEFITS PURCHASING

29 COOPERATIVE; BOARD OF TRUSTEES 1165

30 Sec. 1501.053. TEXAS HEALTH BENEFITS PURCHASING

31 COOPERATIVE: EXECUTIVE DIRECTOR

32 AND OTHER EMPLOYEES 1166

33 Sec. 1501.054. REGIONAL SUBDIVISIONS OF TEXAS HEALTH

34 BENEFITS PURCHASING COOPERATIVE 1166

35 Sec. 1501.055. APPLICABILITY OF PUBLIC INFORMATION

1 LAW TO TEXAS HEALTH BENEFITS

2 PURCHASING COOPERATIVE 1166

3 Sec. 1501.056. PRIVATE PURCHASING COOPERATIVES 1167

4 Sec. 1501.057. IMMUNITY 1168

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6 Sec. 1501.059. SELF-INSURED OR SELF-FUNDED PLAN

7 PROHIBITED 1171

8 Sec. 1501.060. SCOPE OF GROUP COVERAGE 1171

9 Sec. 1501.061. REQUIREMENTS APPLICABLE TO HEALTH

10 BENEFIT PLAN ISSUERS WITH WHICH

11 COOPERATIVE MAY CONTRACT 1171

12 Sec. 1501.062. COOPERATIVE NOT INSURER; AGENTS AND

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17 CHAPTER 1501. HEALTH INSURANCE PORTABILITY AND AVAILABILITY ACT

18 SUBCHAPTER A. GENERAL PROVISIONS

19 Revised Law

20 Sec. 1501.001. SHORT TITLE. This chapter may be cited as
21 the Health Insurance Portability and Availability Act. (V.T.I.C.
22 Art. 26.01.)

23 Source Law

24 Art. 26.01. This chapter may be cited as the
25 Health Insurance Portability and Availability Act.

26 Revised Law

27 Sec. 1501.002. DEFINITIONS. In this chapter:

28 (1) "Agent" means a person who may act as an agent for
29 the sale of a health benefit plan under a license issued under Title
30 13.

31 (2) "Dependent" means:

32 (A) a spouse;

33 (B) a child younger than 25 years of age,
34 including a newborn child;

- 1 (C) a child of any age who is:
2 (i) medically certified as disabled; and
3 (ii) dependent on the parent;
4 (D) an individual who must be covered under:
5 (i) Section 1251.154; or
6 (ii) Section 1201.062; and
7 (E) any other child eligible under an employer's
8 health benefit plan, including a child described by Section
9 1503.003.

10 (3) "Eligible employee" means an employee who works on
11 a full-time basis and who usually works at least 30 hours a week.
12 The term includes a sole proprietor, a partner, and an independent
13 contractor, if the individual is included as an employee under a
14 health benefit plan of a small or large employer. The term does not
15 include an employee who:

16 (A) works on a part-time, temporary, seasonal, or
17 substitute basis;

18 (B) is covered under:
19 (i) another health benefit plan; or
20 (ii) a self-funded or self-insured employee
21 welfare benefit plan that provides health benefits and is
22 established in accordance with the Employee Retirement Income
23 Security Act of 1974 (29 U.S.C. Section 1001 et seq.); or

24 (C) elects not to be covered under the employer's
25 health benefit plan and is covered under:

26 (i) the Medicaid program;
27 (ii) another federal program, including the
28 CHAMPUS program or Medicare program; or
29 (iii) a benefit plan established in another
30 country.

31 (4) "Employee" means an individual employed by an
32 employer.

33 (5) "Health benefit plan" means a group, blanket, or
34 franchise insurance policy, a certificate issued under a group

1 policy, a group hospital service contract, or a group subscriber
2 contract or evidence of coverage issued by a health maintenance
3 organization that provides benefits for health care services. The
4 term does not include:

5 (A) accident-only or disability income insurance
6 coverage or a combination of accident-only and disability income
7 insurance coverage;

8 (B) credit-only insurance coverage;

9 (C) disability insurance coverage;

10 (D) coverage for a specified disease or illness;

11 (E) Medicare services under a federal contract;

12 (F) Medicare supplement and Medicare Select
13 benefit plans regulated in accordance with federal law;

14 (G) long-term care coverage or benefits, nursing
15 home care coverage or benefits, home health care coverage or
16 benefits, community-based care coverage or benefits, or any
17 combination of those coverages or benefits;

18 (H) coverage that provides limited-scope dental
19 or vision benefits;

20 (I) coverage provided by a single service health
21 maintenance organization;

22 (J) workers' compensation insurance coverage or
23 similar insurance coverage;

24 (K) coverage provided through a jointly managed
25 trust authorized under 29 U.S.C. Section 141 et seq. that contains a
26 plan of benefits for employees that is negotiated in a collective
27 bargaining agreement governing wages, hours, and working
28 conditions of the employees that is authorized under 29 U.S.C.
29 Section 157;

30 (L) hospital indemnity or other fixed indemnity
31 insurance coverage;

32 (M) reinsurance contracts issued on a stop-loss,
33 quota-share, or similar basis;

34 (N) short-term major medical contracts;

1 (O) liability insurance coverage, including
2 general liability insurance coverage and automobile liability
3 insurance coverage, and coverage issued as a supplement to
4 liability insurance coverage, including automobile medical payment
5 insurance coverage;

6 (P) coverage for on-site medical clinics;

7 (Q) coverage that provides other limited
8 benefits specified by federal regulations; or

9 (R) other coverage that:

10 (i) is similar to the coverage described by
11 this subdivision under which benefits for medical care are
12 secondary or incidental to other coverage benefits; and

13 (ii) is specified by federal regulations.

14 (6) "Health benefit plan issuer" means an entity
15 authorized under this code or another insurance law of this state
16 that provides health insurance or health benefits in this state,
17 including:

18 (A) an insurance company;

19 (B) a group hospital service corporation
20 operating under Chapter 842;

21 (C) a health maintenance organization operating
22 under Chapter 843; and

23 (D) a stipulated premium company operating under
24 Chapter 884.

25 (7) "Health status related factor" means:

26 (A) health status;

27 (B) medical condition, including both physical
28 and mental illness;

29 (C) claims experience;

30 (D) receipt of health care;

31 (E) medical history;

32 (F) genetic information;

33 (G) evidence of insurability, including
34 conditions arising out of acts of family violence; and

1 (H) disability.

2 (8) "Large employer" means a person who employed an
3 average of at least 51 eligible employees on business days during
4 the preceding calendar year and who employs at least two employees
5 on the first day of the plan year. The term includes a governmental
6 entity subject to Article 3.51-1, 3.51-2, 3.51-4, or 3.51-5, to
7 Subchapter C, Chapter 1364, or to Chapter 1578 that otherwise meets
8 the requirements of this subdivision. For purposes of this
9 definition, a partnership is the employer of a partner.

10 (9) "Large employer health benefit plan" means a
11 health benefit plan offered to a large employer.

12 (10) "Large employer health benefit plan issuer" means
13 a health benefit plan issuer, to the extent that the issuer is
14 offering, delivering, issuing for delivery, or renewing health
15 benefit plans subject to Subchapters C and M.

16 (11) "Person" means an individual, corporation,
17 partnership, or other legal entity.

18 (12) "Preexisting condition provision" means a
19 provision that excludes or limits coverage as to a disease or
20 condition for a specified period after the effective date of
21 coverage.

22 (13) "Premium" means all amounts paid by a small or
23 large employer and eligible employees as a condition of receiving
24 coverage from a small or large employer health benefit plan issuer,
25 including any fees or other contributions associated with a health
26 benefit plan.

27 (14) "Small employer" means a person who employed an
28 average of at least two employees but not more than 50 eligible
29 employees on business days during the preceding calendar year and
30 who employs at least two employees on the first day of the plan
31 year. The term includes a governmental entity subject to Article
32 3.51-1, 3.51-2, 3.51-4, or 3.51-5, to Subchapter C, Chapter 1364,
33 or to Chapter 1578 that otherwise meets the requirements of this
34 subdivision. For purposes of this definition, a partnership is the

1 employer of a partner.

2 (15) "Small employer health benefit plan" means a
3 health benefit plan developed by the commissioner under Subchapter
4 F or any other health benefit plan offered to a small employer in
5 accordance with Section 1501.252(c) or 1501.255.

6 (16) "Small employer health benefit plan issuer" means
7 a health benefit plan issuer, to the extent that the issuer is
8 offering, delivering, issuing for delivery, or renewing health
9 benefit plans subject to Subchapters C-H.

10 (17) "Waiting period" means a period established by an
11 employer that must elapse before an individual who is a potential
12 enrollee in a health benefit plan is eligible to be covered for
13 benefits. (V.T.I.C. Art. 26.02, Subdivs. (2), (8), (9), (10), (11),
14 (12), (13), (15), (16), (17), (21), (24), (25); Art. 26.02,
15 Subdivs. (30), (31), (32), (34), as amended Acts 77th Leg., R.S.,
16 Ch. 823; Art. 26.02, Subdivs. (29), (30), (31), (33), as amended
17 Acts 77th Leg., R.S., Ch. 608.)

18 Source Law

19 Art. 26.02. In this chapter:

20 (2) "Agent" means a person who may act as
21 an agent for the sale of a health benefit plan under a
22 license issued under Section 15 or 15A, Texas Health
23 Maintenance Organization Act (Article 20A.15 or
24 20A.15A, Vernon's Texas Insurance Code), or under
25 Subchapter A, Chapter 21, of this code.

26 (8) "Dependent" means:
27 (A) a spouse;
28 (B) a newborn child;
29 (C) a child younger than 25 years of
30 age;
31 (D) a child of any age who is
32 medically certified as disabled and dependent on the
33 parent;
34 (E) any person who must be covered
35 under:
36 (i) Section 3D or 3E, Article
37 3.51-6, of this code; or
38 (ii) Section 2(L), Chapter 397,
39 Acts of the 54th Legislature, Regular Session, 1955
40 (Article 3.70-2, Vernon's Texas Insurance Code); and
41 (F) any other child eligible under an
42 employer's benefit plan, including a child described
43 by Section 3, Article 21.24-2, of this code.

44 (9) "Eligible employee" means an employee
45 who works on a full-time basis and who usually works at
46 least 30 hours a week. The term also includes a sole
47 proprietor, a partner, and an independent contractor,

1 if the sole proprietor, partner, or independent
2 contractor is included as an employee under a health
3 benefit plan of a small or large employer. The term
4 does not include:

5 (A) an employee who works on a
6 part-time, temporary, seasonal, or substitute basis;
7 or

8 (B) an employee who is covered under:
9 (i) another health benefit
10 plan;

11 (ii) a self-funded or
12 self-insured employee welfare benefit plan that
13 provides health benefits and that is established in
14 accordance with the Employee Retirement Income
15 Security Act of 1974 (29 U.S.C. Section 1001 et seq.);

16 (iii) the Medicaid program if
17 the employee elects not to be covered;

18 (iv) another federal program,
19 including the CHAMPUS program or Medicare program, if
20 the employee elects not to be covered; or

21 (v) a benefit plan established
22 in another country if the employee elects not to be
23 covered.

24 (10) "Employee" means any individual
25 employed by an employer.

26 (11) "Health benefit plan" means a group,
27 blanket, or franchise insurance policy, a certificate
28 issued under a group policy, a group hospital service
29 contract, or a group subscriber contract or evidence
30 of coverage issued by a health maintenance
31 organization that provides benefits for health care
32 services. The term does not include:

33 (A) accident-only or disability
34 income insurance or a combination of accident-only and
35 disability income insurance;

36 (B) credit-only insurance;

37 (C) disability insurance coverage;

38 (D) coverage for a specified disease
39 or illness;

40 (E) Medicare services under a federal
41 contract;

42 (F) Medicare supplement and Medicare
43 Select policies regulated in accordance with federal
44 law;

45 (G) long-term care coverage or
46 benefits, nursing home care coverage or benefits, home
47 health care coverage or benefits, community-based care
48 coverage or benefits, or any combination of those
49 coverages or benefits;

50 (H) coverage that provides
51 limited-scope dental or vision benefits;

52 (I) coverage provided by a single
53 service health maintenance organization;

54 (J) coverage issued as a supplement
55 to liability insurance;

56 (K) workers' compensation or similar
57 insurance;

58 (L) automobile medical payment
59 insurance coverage;

60 (M) jointly managed trusts
61 authorized under 29 U.S.C. Section 141 et seq. that
62 contain a plan of benefits for employees that is
63 negotiated in a collective bargaining agreement
64 governing wages, hours, and working conditions of the
65 employees that is authorized under 29 U.S.C. Section
66 157;

67 (N) hospital indemnity or other fixed
68 indemnity insurance;

1 (O) reinsurance contracts issued on a
2 stop-loss, quota-share, or similar basis;

3 (P) short-term major medical
4 contracts;

5 (Q) liability insurance, including
6 general liability insurance and automobile liability
7 insurance;

8 (R) other coverage that is:

9 (i) similar to the coverage
10 described by this subdivision under which benefits for
11 medical care are secondary or incidental to other
12 insurance benefits; and

13 (ii) specified in federal
14 regulations;

15 (S) coverage for on-site medical
16 clinics; or

17 (T) coverage that provides other
18 limited benefits specified by federal regulations.

19 (12) "Health carrier" means any entity
20 authorized under this code or another insurance law of
21 this state that provides health insurance or health
22 benefits in this state, including an insurance
23 company, a group hospital service corporation under
24 Chapter 20 of this code, a health maintenance
25 organization under the Texas Health Maintenance
26 Organization Act (Chapter 20A, Vernon's Texas
27 Insurance Code), and a stipulated premium company
28 under Chapter 22 of this code.

29 (13) "Health status related factor" means:

30 (A) health status;

31 (B) medical condition, including
32 both physical and mental illness;

33 (C) claims experience;

34 (D) receipt of health care;

35 (E) medical history;

36 (F) genetic information;

37 (G) evidence of insurability,
38 including conditions arising out of acts of family
39 violence; and

40 (H) disability.

41 (15) "Large employer" means an employer
42 who employed an average of at least 51 eligible
43 employees on business days during the preceding
44 calendar year and who employs at least two employees on
45 the first day of the plan year. For purposes of this
46 definition, a partnership is the employer of a
47 partner. A large employer includes a governmental
48 entity subject to Section 1, Chapter 123, Acts of the
49 60th Legislature, Regular Session, 1967 (Article
50 3.51-3, Vernon's Texas Insurance Code), or Article
51 3.51-1, 3.51-2, 3.51-4, 3.51-5, or 3.51-5A of this
52 code that otherwise meets the requirements of this
53 section.

54 (16) "Large employer carrier" means a
55 health carrier, to the extent that carrier is
56 offering, delivering, issuing for delivery, or
57 renewing health benefit plans subject to Subchapter H
58 of this chapter.

59 (17) "Large employer health benefit plan"
60 means a health benefit plan offered to a large
61 employer.

62 (21) "Person" means an individual,
63 corporation, partnership, or other legal entity.

64 (24) "Preexisting condition provision"
65 means a provision that denies, excludes, or limits

1 coverage as to a disease or condition for a specified
2 period after the effective date of coverage.

3 (25) "Premium" means all amounts paid by a
4 small or large employer and eligible employees as a
5 condition of receiving coverage from a small or large
6 employer carrier, including any fees or other
7 contributions associated with a health benefit plan.

8 Art. 26.02. [as amended Acts 77th Leg., R.S., Ch.
9 823] In this chapter:

10 (30) "Small employer" means an employer
11 who employed an average of at least two but not more
12 than 50 eligible employees on business days during the
13 preceding calendar year and who employs at least two
14 eligible employees on the first day of the plan year.
15 For purposes of this definition, a partnership is the
16 employer of a partner. A small employer includes a
17 governmental entity subject to Section 1, Chapter 123,
18 Acts of the 60th Legislature, Regular Session, 1967
19 (Article 3.51-3, Vernon's Texas Insurance Code), or
20 Article 3.51-1, 3.51-2, 3.51-4, 3.51-5, or 3.51-5A of
21 this code that otherwise meets the requirements of
22 this section and elects to be treated as a small
23 employer.

24 (31) "Small employer carrier" means a
25 health carrier, to the extent that that carrier is
26 offering, delivering, issuing for delivery, or
27 renewing health benefit plans subject to Subchapters
28 C-G of this chapter under Article 26.06(a) of this
29 code.

30 (32) "Small employer health benefit plan"
31 means a plan developed by the commissioner under
32 Subchapter E of this chapter or any other health
33 benefit plan offered to a small employer in accordance
34 with Article 26.42(c) or 26.48 of this code.

35 (34) "Waiting period" means a period
36 established by an employer that must pass before an
37 individual who is a potential enrollee in a health
38 benefit plan is eligible to be covered for benefits.

39 Art. 26.02. [as amended Acts 77th Leg., R.S.,
40 Ch. 608] In this chapter:

41 (29) "Small employer" means an employer
42 who employed an average of at least two employees but
43 not more than 50 eligible employees on business days
44 during the preceding calendar year and who employs at
45 least two employees on the first day of the plan year.
46 For purposes of this definition, a partnership is the
47 employer of a partner. A small employer includes a
48 governmental entity subject to Section 1, Chapter 123,
49 Acts of the 60th Legislature, Regular Session, 1967
50 (Article 3.51-3, Vernon's Texas Insurance Code), or
51 Article 3.51-1, 3.51-2, 3.51-4, 3.51-5, or 3.51-5A of
52 this code that otherwise meets the requirements of
53 this section.

54 (30) "Small employer carrier" means a
55 health carrier, to the extent that that carrier is
56 offering, delivering, issuing for delivery, or
57 renewing health benefit plans subject to Subchapters
58 C-G of this chapter under Article 26.06(a) of this
59 code.

60 (31) "Small employer health benefit plan"
61 means a plan developed by the commissioner under
62 Subchapter E of this chapter or any other health
63 benefit plan offered to a small employer in accordance

1 with Article 26.42(c) or 26.48 of this code.

2 (33) "Waiting period" means a period
3 established by an employer that must pass before an
4 individual who is a potential enrollee in a health
5 benefit plan is eligible to be covered for benefits.

6 Revisor's Note

7 (1) Subdivision (2), V.T.I.C. Article 26.02,
8 defines "agent" as a person "who may act as an agent
9 for the sale of a health benefit plan under a license
10 issued under Section 15 or 15A, Texas Health
11 Maintenance Organization Act (Article 20A.15 or
12 20A.15A, Vernon's Texas Insurance Code), or under
13 Subchapter A, Chapter 21, of this code." The revised
14 law omits the references to Articles 20A.15 and
15 20A.15A because those sections were repealed by
16 Chapter 716, Acts of the 75th Legislature, Regular
17 Session, 1997; that act also prohibited the issuance
18 or renewal of a license under those sections after
19 December 31, 1997.

20 (2) Subdivision (8)(E), V.T.I.C. Article 26.02,
21 defines "dependent" to include "any person who must be
22 covered under . . . Section 3D or 3E, Article 3.51-6,
23 of this code; or . . . Section 2(L), Chapter 397, Acts
24 of the 54th Legislature, Regular Session, 1955
25 (Article 3.70-2, Vernon's Texas Insurance Code)."
26 Because the reference to Subsection (L), Article
27 3.70-2, revised as Section 1201.062 of this code,
28 includes the persons described by Section 3E, Article
29 3.51-6, revised as Section 1251.151 of this code, the
30 revised law omits the reference to the latter
31 provision.

32 (3) Subdivision (11)(F), V.T.I.C. Article
33 26.02, excludes "Medicare supplement and Medicare
34 Select policies" from the definition of "health
35 benefit plan." The revised law substitutes "Medicare
36 supplement and Medicare Select benefit plans" for

1 "Medicare supplement and Medicare Select policies"
2 because federal and state law permit Medicare
3 supplement and Medicare Select benefits to be provided
4 through health maintenance organizations, which are
5 not insurers. Consequently, "benefit plan" is a more
6 accurate term than "policy."

7 (4) Subdivision (12), V.T.I.C. Article 26.02,
8 defines "health carrier." Subdivision (16), V.T.I.C.
9 Article 26.02, defines "large employer carrier."
10 Subdivision (31), V.T.I.C. Article 26.02, as amended
11 by Chapter 823, Acts of the 77th Legislature, Regular
12 Session, 2001, and Subdivision (30), V.T.I.C. Article
13 26.02, as amended by Chapter 608, Acts of the 77th
14 Legislature, Regular Session, 2001, define "small
15 employer carrier." "Carrier" is a term used in
16 conjunction with traditional insurance. Included
17 within the definition of "health carrier" are entities
18 such as health maintenance organizations that are not
19 insurers. Consequently, "benefit plan issuer" is a
20 more accurate term than "carrier," and the revised law
21 substitutes "health benefit plan issuer" for "health
22 carrier," "large employer health benefit plan issuer"
23 for "large employer carrier," and "small employer
24 health benefit plan issuer" for "small employer
25 carrier." These changes, as well as any comparable
26 changes necessary to ensure consistent terminology,
27 are made throughout this chapter.

28 (5) Subdivision (24), V.T.I.C. Article 26.02,
29 refers to a provision that "denies, excludes, or
30 limits" coverage. The reference to "denies" is
31 omitted from the revised law because in this context
32 "denies" is included within the meaning of "excludes."

33 Revised Law

34 Sec. 1501.003. APPLICABILITY: SMALL EMPLOYER HEALTH

1 BENEFIT PLANS. An individual or group health benefit plan is a
2 small employer health benefit plan subject to Subchapters C-H if it
3 provides health care benefits covering two or more eligible
4 employees of a small employer and:

5 (1) the employer pays a portion of the premium or
6 benefits;

7 (2) the employer or a covered individual treats the
8 health benefit plan as part of a plan or program for purposes of
9 Section 106 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section
10 106 or 162); or

11 (3) the health benefit plan is an employee welfare
12 benefit plan under 29 C.F.R. Section 2510.3-1(j). (V.T.I.C.
13 Art. 26.06, Subsec. (a).)

14 Source Law

15 Art. 26.06. (a) An individual or group health
16 benefit plan is subject to Subchapters C-G of this
17 chapter if it provides health care benefits covering
18 two or more eligible employees of a small employer and
19 if:

20 (1) a portion of the premium or benefits is
21 paid by a small employer;

22 (2) the health benefit plan is treated by
23 the employer or by a covered individual as part of a
24 plan or program for the purposes of Section 106 or 162,
25 Internal Revenue Code of 1986 (26 U.S.C. Section 106 or
26 162); or

27 (3) the health benefit plan is an employee
28 welfare benefit plan under 29 C.F.R. Section
29 2510.3-1(j).

30 Revised Law

31 Sec. 1501.004. APPLICABILITY: LARGE EMPLOYER HEALTH
32 BENEFIT PLANS. An individual or group health benefit plan is a
33 large employer health benefit plan subject to Subchapters C and M if
34 the plan provides health care benefits to eligible employees of a
35 large employer and:

36 (1) the employer pays a portion of the premium or
37 benefits;

38 (2) the employer or a covered individual treats the
39 health benefit plan as part of a plan or program for purposes of
40 Section 106 or 162, Internal Revenue Code of 1986 (26 U.S.C. Section
41 106 or 162); or

1 (3) the health benefit plan is an employee welfare
2 benefit plan under 29 C.F.R. Section 2510.3-1(j). (V.T.I.C.
3 Art. 26.81, Subsec. (a).)

4 Source Law

5 Art. 26.81. (a) An individual or group health
6 benefit plan is subject to this subchapter if the plan
7 provides health care benefits to eligible employees of
8 a large employer and if:

9 (1) a portion of the premium or benefits is
10 paid by a large employer;

11 (2) the health benefit plan is treated by
12 the employer or by a covered individual as part of a
13 plan or program for the purposes of Section 106 or 162,
14 Internal Revenue Code of 1986 (26 U.S.C. Section 106 or
15 162); or

16 (3) the health benefit plan is an employee
17 welfare benefit plan under 29 C.F.R. Section
18 2510.3-1(j).

19 Revised Law

20 Sec. 1501.005. EXCEPTION: CERTAIN INDIVIDUALLY
21 UNDERWRITTEN POLICIES. Except as provided by Section 1501.003 or
22 1501.004, this chapter does not apply to an individual health
23 insurance policy that is subject to individual underwriting, even
24 if the premium is paid through a payroll deduction method.
25 (V.T.I.C. Art. 26.06, Subsec. (c); Art. 26.81, Subsec. (c).)

26 Source Law

27 [Art. 26.06]

28 (c) Except as provided by Subsection (a) of this
29 article, this chapter does not apply to an individual
30 health insurance policy that is subject to individual
31 underwriting, even if the premium is remitted through
32 a payroll deduction method.

33 [Art. 26.81]

34 (c) Except as provided by Subsection (a) of this
35 article, this subchapter does not apply to an
36 individual health insurance policy that is subject to
37 individual underwriting, even if the premium is
38 remitted through payroll deduction.

39 Revised Law

40 Sec. 1501.006. CERTIFICATION. (a) In accordance with
41 rules adopted by the commissioner, each health benefit plan issuer
42 shall certify that the issuer is offering, delivering, issuing for
43 delivery, or renewing, or that the issuer intends to offer,
44 deliver, issue for delivery, or renew:

45 (1) a health benefit plan to or through a small

1 employer in this state that is subject to this chapter; or

2 (2) a health benefit plan to or through a large
3 employer in this state that is subject to this chapter.

4 (b) A health benefit plan issuer must submit a revised
5 certification to the commissioner only if the issuer changes its
6 status as a small or large employer health benefit plan issuer or
7 changes its intent to become a small or large employer health
8 benefit plan issuer to the extent that its previous certification
9 ceases to be accurate.

10 (c) The certification must include a statement that the
11 health benefit plan issuer is complying with this chapter to the
12 extent it applies to the issuer. (V.T.I.C. Arts. 26.07, 26.82.)

13 Source Law

14 Art. 26.07. (a) Each health carrier shall
15 certify, in accordance with rules adopted by the
16 commissioner, that the health carrier is offering,
17 delivering, issuing for delivery, or renewing, or that
18 the health carrier intends to offer, deliver, issue
19 for delivery, or renew a health benefit plan to or
20 through a small employer in this state that is subject
21 to this chapter under Article 26.06(a) of this code.

22 (b) A health carrier must submit a revised
23 certification to the commissioner only if the health
24 carrier changes its status as a small employer carrier
25 or changes its intent to become a small employer health
26 carrier to the extent that its previous certification
27 ceases to be accurate.

28 (c) The certification shall include a statement
29 that the health carrier is complying with this chapter
30 to the extent it is applicable to the carrier.

31 Art. 26.82. (a) Each health carrier shall
32 certify, in accordance with rules adopted by the
33 commissioner, that the health carrier is offering,
34 delivering, issuing for delivery, or renewing, or that
35 the health carrier intends to offer, deliver, issue
36 for delivery, or renew a health benefit plan to or
37 through a large employer in this state that is subject
38 to this subchapter under Article 26.81 of this code.

39 (b) A health carrier must submit a revised
40 certification to the commissioner only if the health
41 carrier changes its status as a large employer carrier
42 or changes its intent to become a small employer health
43 carrier to the extent that its previous certification
44 ceases to be accurate.

45 (c) The certification shall include a statement
46 that the health carrier is complying with this chapter
47 to the extent it is applicable to the carrier.

48 Revised Law

49 Sec. 1501.007. AFFILIATES. (a) In this section,
50 "affiliate" has the meaning described by Section 823.003.

1 (b) For purposes of this chapter, health benefit plan
2 issuers that are affiliates or that are eligible to file a
3 consolidated tax return are considered to be one issuer, and a
4 restriction imposed by this chapter applies as if the health
5 benefit plans delivered or issued for delivery to small employers
6 in this state by the affiliates were issued by one issuer.

7 (c) Notwithstanding Subsection (b), a health maintenance
8 organization that is an affiliate is considered to be a separate
9 health benefit plan issuer for purposes of this chapter. (V.T.I.C.
10 Art. 26.03.)

11 Source Law

12 Art. 26.03. (a) For purposes of this chapter,
13 health carriers that are affiliates or that are
14 eligible to file a consolidated tax return are
15 considered to be one carrier, and a restriction
16 imposed by this chapter applies as if the health
17 benefit plans delivered or issued for delivery to
18 small employers in this state by the affiliates were
19 issued by one carrier.

20 (b) An affiliate that is a health maintenance
21 organization is considered to be a separate health
22 carrier for purposes of this chapter.

23 (c) In this article, "affiliate" has the meaning
24 assigned by Article 21.49-1 of this code.

25 Revised Law

26 Sec. 1501.008. LATE ENROLLEES. (a) For purposes of this
27 chapter, an employee or dependent eligible for enrollment in a
28 small or large employer's health benefit plan is a late enrollee if
29 the individual requests enrollment after the expiration of:

30 (1) the initial enrollment period established under
31 the terms of the first plan for which the individual was eligible
32 through the small or large employer; or

33 (2) an open enrollment period under Section
34 1501.156(a) or 1501.606(a).

35 (b) An employee or dependent eligible for enrollment is not
36 a late enrollee if the individual:

37 (1) was covered under another health benefit plan or
38 self-funded employer health benefit plan at the time the individual
39 was eligible to enroll;

40 (2) declined enrollment in writing, at the time of the

1 initial eligibility for enrollment, stating that coverage under
2 another health benefit plan or self-funded employer health benefit
3 plan was the reason for declining enrollment;

4 (3) has lost coverage under the other health benefit
5 plan or self-funded employer health benefit plan as a result of:

6 (A) the termination of employment;

7 (B) a reduction in the number of hours of
8 employment;

9 (C) the termination of the other plan's coverage;

10 (D) the termination of contributions toward the
11 premium made by the employer; or

12 (E) the death of a spouse or divorce; and

13 (4) requests enrollment not later than the 31st day
14 after the date coverage under the other health benefit plan or
15 self-funded employer health benefit plan terminates.

16 (c) An employee or dependent eligible for enrollment is also
17 not a late enrollee if the individual is:

18 (1) employed by an employer that offers multiple
19 health benefit plans and the individual elects a different health
20 benefit plan during an open enrollment period;

21 (2) a spouse for whom a court has ordered coverage
22 under a covered employee's plan and the request for enrollment of
23 the spouse is made not later than the 31st day after the date the
24 court order is issued;

25 (3) a child for whom a court has ordered coverage under
26 a covered employee's plan and the request for enrollment is made not
27 later than the 31st day after the date the employer receives the
28 court order; or

29 (4) a child of a covered employee who has lost coverage
30 under Title XIX of the Social Security Act (42 U.S.C. Section 1396
31 et seq.), other than coverage consisting solely of benefits under
32 Section 1928 of that Act (42 U.S.C. Section 1396s), or under Chapter
33 62, Health and Safety Code, and the request for enrollment is made
34 not later than the 31st day after the date on which the child loses

1 coverage. (V.T.I.C. Art. 26.02, Subdiv. (18).)

2 Source Law

3 Art. 26.02. In this chapter:

4 (18) "Late enrollee" means any employee or
5 dependent eligible for enrollment who requests
6 enrollment in a small or large employer's health
7 benefit plan after the expiration of the initial
8 enrollment period established under the terms of the
9 first plan for which that employee or dependent was
10 eligible through the small or large employer or after
11 the expiration of an open enrollment period under
12 Article 26.21(h) or 26.83 of this code. An employee or
13 dependent eligible for enrollment is not a late
14 enrollee if:

15 (A) the individual:

16 (i) was covered under another
17 health benefit plan or self-funded employer health
18 benefit plan at the time the individual was eligible to
19 enroll;

20 (ii) declines in writing, at
21 the time of the initial eligibility, stating that
22 coverage under another health benefit plan or
23 self-funded employer health benefit plan was the
24 reason for declining enrollment;

25 (iii) has lost coverage under
26 another health benefit plan or self-funded employer
27 health benefit plan as a result of:

28 (a) the termination of
29 employment;

30 (b) the reduction in the
31 number of hours of employment;

32 (c) the termination of the
33 other plan's coverage;

34 (d) the termination of
35 contributions toward the premium made by the employer;
36 or

37 (e) the death of a spouse
38 or divorce; and

39 (iv) requests enrollment not
40 later than the 31st day after the date on which
41 coverage under the other health benefit plan or
42 self-funded employer health benefit plan terminates;

43 (B) the individual is employed by an
44 employer who offers multiple health benefit plans and
45 the individual elects a different health benefit plan
46 during an open enrollment period;

47 (C) a court has ordered coverage to
48 be provided for a spouse under a covered employee's
49 plan and request for enrollment is made not later than
50 the 31st day after the date on which the court order is
51 issued;

52 (D) a court has ordered coverage to
53 be provided for a child under a covered employee's plan
54 and the request for enrollment is made not later than
55 the 31st day after the date on which the employer
56 receives the court order; or

57 (E) the individual is a child of a
58 covered employee who has lost coverage under Title XIX
59 of the Social Security Act (42 U.S.C. Section 1396 et
60 seq.), other than coverage consisting solely of
61 benefits under Section 1928 of that Act (42 U.S.C.
62 Section 1396s), or under Chapter 62, Health and Safety
63 Code, and the request for enrollment is made not later
64 than the 31st day after the date on which the child

1 loses coverage.

2 Revised Law

3 Sec. 1501.009. SCHOOL DISTRICT ELECTION. (a) An
4 independent school district may elect to participate as a small
5 employer without regard to the number of eligible employees in the
6 district. An independent school district that makes the election
7 is treated as a small employer under this chapter for all purposes.

8 (b) An independent school district that is participating in
9 the uniform group coverage program established under Article 3.50-7
10 may not participate in the small employer market under this section
11 for health insurance coverage and may not renew a health insurance
12 contract obtained in accordance with this section after the date on
13 which the program of coverages provided under Article 3.50-7 is
14 implemented. This subsection does not affect a contract for the
15 provision of optional coverages not included in a health benefit
16 plan under this chapter. (V.T.I.C. Art. 26.036.)

17 Source Law

18 Art. 26.036. (a) An independent school
19 district may elect to participate in the small
20 employer market without regard to the number of
21 eligible employees of the independent school district.

22 (b) An independent school district that elects
23 to participate in the small employer market under this
24 article is treated as a small employer under this
25 chapter for all purposes.

26 (c) An independent school district that is
27 participating in the uniform group coverage program
28 established under Article 3.50-7 of this code may not
29 participate in the small employer market under this
30 article for health insurance coverage and may not
31 renew a health insurance contract obtained in
32 accordance with this article after the date on which
33 the program of coverages provided under Article 3.50-7
34 of this code is implemented. This subsection does not
35 affect a contract for the provision of optional
36 coverages not included in a health benefits plan under
37 this chapter.

38 Revised Law

39 Sec. 1501.010. GENERAL RULES. The commissioner shall
40 adopt rules necessary to:

41 (1) implement this chapter; and

42 (2) meet the minimum requirements of federal law,
43 including regulations. (V.T.I.C. Art. 26.04.)

1 Source Law

2 Art. 26.04. The commissioner shall adopt rules as
3 necessary to implement this chapter and to meet the
4 minimum requirements of federal law and regulations.

5 Revised Law

6 Sec. 1501.011. DETERMINATION OF EMPLOYER STATUS FOR CERTAIN
7 EMPLOYERS. (a) For an employer that did not exist throughout the
8 calendar year preceding the year in which the determination of
9 whether the employer is a small employer is made, the determination
10 is based on the average number of employees and eligible employees
11 the employer reasonably expects to employ on business days in the
12 calendar year in which the determination is made.

13 (b) For an employer that did not exist throughout the
14 calendar year preceding the year in which the determination of
15 whether the employer is a large employer is made, the determination
16 is based on the average number of eligible employees the employer
17 reasonably expects to employ on business days in the calendar year
18 in which the determination is made. (V.T.I.C. Art. 26.06, Subsec.
19 (b); Art. 26.81, Subsec. (b).)

20 Source Law

21 [Art. 26.06]

22 (b) For an employer who was not in existence
23 throughout the calendar year preceding the year in
24 which the determination of whether the employer is a
25 small employer is made, the determination is based on
26 the average number of employees and eligible employees
27 the employer reasonably expects to employ on business
28 days in the calendar year in which the determination is
29 made.

30 [Art. 26.81]

31 (b) For an employer who was not in existence
32 throughout the calendar year preceding the year in
33 which the determination of whether the employer is a
34 large employer is made, the determination is based on
35 the average number of eligible employees the employer
36 reasonably expects to employ on business days in the
37 calendar year in which the determination is made.

38 Revisor's Note
39 (End of Subchapter)

40 V.T.I.C. Article 26.05 provides that a reference
41 in V.T.I.C. Chapter 26 to a statute "applies to all
42 reenactments, revisions, or amendments" of the
43 statute. The revised law omits this provision as

1 unnecessary because it duplicates Section 311.027,
2 Government Code (Code Construction Act), applicable to
3 the revised law. The omitted law reads:

4 Art. 26.05. A reference in this
5 chapter to a statutory provision applies to
6 all reenactments, revisions, or amendments
7 of that statutory provision.

8 [Sections 1501.012-1501.050 reserved for expansion]

9 SUBCHAPTER B. PURCHASING COOPERATIVES

10 Revised Law

11 Sec. 1501.051. DEFINITIONS. In this subchapter:

12 (1) "Board of directors" means the board of directors
13 elected by a private purchasing cooperative.

14 (2) "Board of trustees" means the board of trustees of
15 the Texas cooperative.

16 (3) "Cooperative" means a purchasing cooperative
17 established under this subchapter.

18 (4) "Texas cooperative" means the Texas Health
19 Benefits Purchasing Cooperative established under Section
20 1501.052. (V.T.I.C. Art. 26.11.)

21 Source Law

22 Art. 26.11. In this subchapter:

23 (1) "Board of trustees" means the board of
24 trustees of the Texas cooperative.

25 (2) "Board of directors" means the board
26 of directors elected by a private purchasing
27 cooperative.

28 (3) "Cooperative" means a purchasing
29 cooperative established under this subchapter.

30 (4) "Texas cooperative" means the Texas
31 Health Benefits Purchasing Cooperative, a nonprofit
32 corporation, established under Article 26.13 of this
33 code.

34 Revisor's Note

35 Subdivision (4), V.T.I.C. Article 26.11, refers
36 to the Texas Health Benefits Purchasing Cooperative as
37 a "nonprofit corporation." The revised law omits the
38 quoted language because Subsection (a), V.T.I.C.
39 Article 26.13, revised as Section 1501.052(a),
40 provides that the cooperative is a nonprofit
41 corporation. It is unnecessary to refer twice to the

1 cooperative's nonprofit status, and Section
2 1501.052(a) is the more appropriate location for the
3 reference because that section is a substantive
4 provision.

5 Revised Law

6 Sec. 1501.052. TEXAS HEALTH BENEFITS PURCHASING
7 COOPERATIVE; BOARD OF TRUSTEES. (a) The Texas Health Benefits
8 Purchasing Cooperative is a nonprofit corporation established to
9 make health care coverage available to small and large employers
10 and their eligible employees and the eligible employees'
11 dependents.

12 (b) The Texas cooperative is administered by a board of
13 trustees of six members appointed by the governor with the advice
14 and consent of the senate. Three members must represent employers,
15 two members must represent employees, and one member must represent
16 the public.

17 (c) Members of the board of trustees serve staggered
18 six-year terms, with the terms of two members expiring February 1 of
19 each odd-numbered year.

20 (d) A member of the board of trustees may not be compensated
21 for serving on the board but is entitled to reimbursement for actual
22 expenses incurred in performing functions as a member of the board
23 as provided by the General Appropriations Act. (V.T.I.C.
24 Art. 26.13, Subsecs. (a), (b), (c), (d).)

25 Source Law

26 Art. 26.13. (a) The Texas Health Benefits
27 Purchasing Cooperative is a nonprofit corporation
28 established to make health care coverage available to
29 small and large employers and their eligible employees
30 and eligible employees' dependents.

31 (b) The Texas cooperative is administered by a
32 six-member board of trustees appointed by the governor
33 with the advice and consent of the senate. Three
34 members must represent employers, two members must
35 represent employees, and one member must represent the
36 public.

37 (c) The appointed members of the board of
38 trustees serve staggered six-year terms, with the
39 terms of two members expiring February 1 of each
40 odd-numbered year.

41 (d) A member of the board of trustees may not be
42 compensated for serving on the board of trustees but is

1 entitled to reimbursement for actual expenses incurred
2 in performing functions as a member of the board of
3 trustees as provided by the General Appropriations
4 Act.

5 Revised Law

6 Sec. 1501.053. TEXAS HEALTH BENEFITS PURCHASING
7 COOPERATIVE: EXECUTIVE DIRECTOR AND OTHER EMPLOYEES. (a) The
8 board of trustees shall employ an executive director. The
9 executive director may hire other employees of the Texas
10 cooperative as necessary.

11 (b) Salaries for employees of the Texas cooperative and
12 related costs may be paid from administrative fees collected from
13 employers and participating health benefit plan issuers or other
14 sources of funding arranged by the Texas cooperative. (V.T.I.C.
15 Art. 26.13, Subsecs. (e), (g).)

16 Source Law

17 (e) The board of trustees shall employ an
18 executive director. The executive director may hire
19 other employees as necessary.

20 (g) Salaries for employees of the Texas
21 cooperative and related costs may be paid from
22 administrative fees collected from employers and
23 participating carriers or other sources of funding
24 arranged by the Texas cooperative.

25 Revised Law

26 Sec. 1501.054. REGIONAL SUBDIVISIONS OF TEXAS HEALTH
27 BENEFITS PURCHASING COOPERATIVE. The board of trustees may:

28 (1) develop regional subdivisions of the Texas
29 cooperative; and

30 (2) authorize each subdivision to separately exercise
31 the powers and duties of a cooperative. (V.T.I.C. Art. 26.13,
32 Subsec. (f).)

33 Source Law

34 (f) The board of trustees may develop regional
35 subdivisions of the Texas cooperative and may
36 authorize each subdivision to separately exercise the
37 powers and duties of a cooperative.

38 Revised Law

39 Sec. 1501.055. APPLICABILITY OF PUBLIC INFORMATION LAW TO
40 TEXAS HEALTH BENEFITS PURCHASING COOPERATIVE. The Texas

1 cooperative is subject to the public information law, Chapter 552,
2 Government Code. (V.T.I.C. Art. 26.12, Subsec. (b).)

3 Source Law

4 (b) The Texas cooperative is subject to the open
5 records law, Chapter 424, Acts of the 63rd
6 Legislature, Regular Session, 1973 (Article 6252-17a,
7 Vernon's Texas Civil Statutes).

8 Revisor's Note

9 Subsection (b), V.T.I.C. Article 26.12, refers to
10 "the open records law, Chapter 424, Acts of the 63rd
11 Legislature, Regular Session, 1973 (Article 6252-17a,
12 Vernon's Texas Civil Statutes)." That statute was
13 codified in 1993 as Chapter 552, Government Code.
14 Section 1, Chapter 1035, Acts of the 74th Legislature,
15 Regular Session, 1995, changed the heading of Chapter
16 552, Government Code, from "Open Records" to "Public
17 Information." The revised law is drafted accordingly.

18 Revised Law

19 Sec. 1501.056. PRIVATE PURCHASING COOPERATIVES. (a) Two
20 or more small or large employers may form a private cooperative to
21 purchase small or large employer health benefit plans. The
22 cooperative must be organized as a nonprofit corporation and has
23 the rights and duties provided by the Texas Non-Profit Corporation
24 Act (Article 1396-1.01 et seq., Vernon's Texas Civil Statutes).

25 (b) On receipt of a certificate of incorporation or
26 certificate of authority from the secretary of state, the
27 cooperative shall file written notice of the receipt of the
28 certificate and a copy of the cooperative's organizational
29 documents with the commissioner.

30 (c) Annually, the board of directors shall file with the
31 commissioner a statement of all amounts collected and expenses
32 incurred for each of the preceding three years. (V.T.I.C.
33 Art. 26.14, Subsecs. (a), (b), (c).)

34 Source Law

35 Art. 26.14. (a) Two or more small or large
36 employers may form a cooperative for the purchase of

1 small or large employer health benefit plans. A
2 cooperative must be organized as a nonprofit
3 corporation and has the rights and duties provided by
4 the Texas Non-Profit Corporation Act (Article
5 1396-1.01 et seq., Vernon's Texas Civil Statutes).

6 (b) On receipt of a certificate of incorporation
7 or certificate of authority from the secretary of
8 state, the cooperative shall file written notification
9 of the receipt of the certificate and a copy of the
10 cooperative's organizational documents with the
11 commissioner.

12 (c) The board of directors shall file annually
13 with the commissioner a statement of all amounts
14 collected and expenses incurred for each of the
15 preceding three years.

16 Revised Law

17 Sec. 1501.057. IMMUNITY. (a) The Texas cooperative or a
18 member of the board of trustees, the executive director, or an
19 employee or agent of the Texas cooperative is not liable for:

20 (1) an act performed in good faith in the execution of
21 duties in connection with the cooperative; or

22 (2) an independent action of a small employer health
23 benefit plan issuer or a person who provides health care services
24 under a health benefit plan.

25 (b) A private purchasing cooperative or a member of the
26 board of directors, the executive director, or an employee or agent
27 of the cooperative is not liable for:

28 (1) an act performed in good faith in the execution of
29 duties in connection with the cooperative; or

30 (2) an independent action of a small or large employer
31 health benefit plan issuer or a person who provides health care
32 services under a health benefit plan. (V.T.I.C. Art. 26.13,
33 Subsec. (h); Art. 26.14, Subsec. (d).)

34 Source Law

35 [Art. 26.13]

36 (h) The Texas cooperative or a member of the
37 board of trustees, the executive director, or an
38 employee or agent of the Texas cooperative is not
39 liable for:

40 (1) an act performed in good faith in the
41 execution of duties in connection with the Texas
42 cooperative; or

43 (2) an independent action of a small
44 employer insurance carrier or a person who provides
45 health care services under a health benefit plan.

46 [Art. 26.14]

47 (d) A purchasing cooperative or a member of the

1 board of directors, the executive director, or an
2 employee or agent of a purchasing cooperative is not
3 liable for:

4 (1) an act performed in good faith in the
5 execution of duties in connection with the purchasing
6 cooperative; or

7 (2) an independent action of a small or
8 large employer insurance carrier or a person who
9 provides health care services under a health benefit
10 plan.

11 Revised Law

12 Sec. 1501.058. POWERS AND DUTIES OF COOPERATIVES. (a) A
13 cooperative shall:

14 (1) arrange for small or large employer health benefit
15 plan coverage for small or large employer groups that participate
16 in the cooperative by contracting with small or large employer
17 health benefit plan issuers that meet the requirements established
18 by Section 1501.061;

19 (2) collect premiums to cover the cost of:

20 (A) small or large employer health benefit plan
21 coverage purchased through the cooperative; and

22 (B) the cooperative's administrative expenses;

23 (3) establish administrative and accounting
24 procedures for the operation of the cooperative;

25 (4) establish procedures under which an applicant for
26 or participant in coverage issued through the cooperative may have
27 a grievance reviewed by an impartial person;

28 (5) contract with small or large employer health
29 benefit plan issuers to provide services to small or large
30 employers covered through the cooperative; and

31 (6) develop and implement a plan to maintain public
32 awareness of the cooperative and publicize the eligibility
33 requirements for, and the procedures for enrollment in, coverage
34 through the cooperative.

35 (b) A cooperative may:

36 (1) contract with agents to market coverage issued
37 through the cooperative;

38 (2) contract with a small or large employer health
39 benefit plan issuer or third-party administrator to provide

1 administrative services to the cooperative;

2 (3) negotiate the premiums paid by its members; and

3 (4) offer other ancillary products and services to its
4 members that are customarily offered in conjunction with health
5 benefit plans.

6 (c) A cooperative shall comply with:

7 (1) federal laws applicable to cooperatives and health
8 benefit plans issued through cooperatives, to the extent required
9 by state law or rules adopted by the commissioner; and

10 (2) state laws applicable to cooperatives and health
11 benefit plans issued through cooperatives. (V.T.I.C. Art. 26.15,
12 Subsecs. (a), (d).)

13 Source Law

14 Art. 26.15. (a) A cooperative:

15 (1) shall arrange for small or large
16 employer health benefit plan coverage for small or
17 large employer groups who participate in the
18 cooperative by contracting with small or large
19 employer carriers who meet the criteria established by
20 Subsection (b) of this article;

21 (2) shall collect premiums to cover the
22 cost of:

23 (A) small or large employer health
24 benefit plan coverage purchased through the
25 cooperative; and

26 (B) the cooperative's administrative
27 expenses;

28 (3) may contract with agents to market
29 coverage issued through the cooperative;

30 (4) shall establish administrative and
31 accounting procedures for the operation of the
32 cooperative;

33 (5) shall establish procedures under which
34 an applicant for or participant in coverage issued
35 through the cooperative may have a grievance reviewed
36 by an impartial person;

37 (6) may contract with a small or large
38 employer carrier or third-party administrator to
39 provide administrative services to the cooperative;

40 (7) shall contract with small or large
41 employer carriers for the provision of services to
42 small or large employers covered through the
43 cooperative;

44 (8) shall develop and implement a plan to
45 maintain public awareness of the cooperative and
46 publicize the eligibility requirements for, and the
47 procedures for enrollment in coverage through, the
48 cooperative;

49 (9) may negotiate the premiums paid by its
50 members; and

51 (10) may offer such other ancillary
52 products and services to its members as are
53 customarily offered in conjunction with health benefit
54 plans.

1 (d) A cooperative shall comply with federal laws
2 applicable to cooperatives and health benefit plans
3 issued through cooperatives, to the extent required by
4 state law or rules adopted by the commissioner of
5 insurance. A cooperative shall comply with state laws
6 applicable to cooperatives and health benefit plans
7 issued through cooperatives.

8 Revisor's Note

9 Subsection (d), V.T.I.C. Article 26.15, refers to
10 the "commissioner of insurance." Chapter 31,
11 Insurance Code, defines "commissioner" for purposes of
12 this code and the other insurance laws of this state to
13 mean the commissioner of insurance. The revised law is
14 drafted accordingly.

15 Revised Law

16 Sec. 1501.059. SELF-INSURED OR SELF-FUNDED PLAN
17 PROHIBITED. A cooperative may not self-insure or self-fund any
18 health benefit plan or portion of a plan. (V.T.I.C. Art. 26.15,
19 Subsec. (c).)

20 Source Law

21 (c) A cooperative may not self-insure or
22 self-fund any health benefit plan or portion of a plan.

23 Revised Law

24 Sec. 1501.060. SCOPE OF GROUP COVERAGE. Subchapter B,
25 Chapter 1251, does not limit the type of group that may be covered
26 by a group health benefit plan issued through a cooperative.
27 (V.T.I.C. Art. 26.12, Subsec. (a).)

28 Source Law

29 Art. 26.12. (a) Section 1(a), Article 3.51-6,
30 of this code, does not limit the type of group that may
31 be covered by a group health benefit plan issued
32 through a cooperative.

33 Revised Law

34 Sec. 1501.061. REQUIREMENTS APPLICABLE TO HEALTH BENEFIT
35 PLAN ISSUERS WITH WHICH COOPERATIVE MAY CONTRACT. A cooperative
36 may contract only with a small or large employer health benefit plan
37 issuer that desires to offer coverage through the cooperative and
38 that demonstrates that the issuer:

39 (1) is in good standing with the department;

1 (2) has the capacity to administer health benefit
2 plans;

3 (3) is able to monitor and evaluate the quality and
4 cost-effectiveness of care and applicable procedures;

5 (4) is able to conduct utilization management and
6 establish applicable procedures and policies;

7 (5) is able to ensure that enrollees have adequate
8 access to health care providers, including adequate numbers and
9 types of providers;

10 (6) has a satisfactory grievance procedure and is able
11 to respond to enrollees' calls, questions, and complaints; and

12 (7) has financial capacity, either through satisfying
13 financial solvency standards, as applied by the commissioner, or
14 through appropriate reinsurance or other risk-sharing mechanisms.
15 (V.T.I.C. Art. 26.15, Subsec. (b).)

16 Source Law

17 (b) A cooperative may contract only with small
18 or large employer carriers who desire to offer
19 coverage through the cooperative and who demonstrate:

20 (1) that the carrier is a health carrier or
21 health maintenance organization licensed and in good
22 standing with the department;

23 (2) the capacity to administer the health
24 benefit plans;

25 (3) the ability to monitor and evaluate
26 the quality and cost effectiveness of care and
27 applicable procedures;

28 (4) the ability to conduct utilization
29 management and applicable procedures and policies;

30 (5) the ability to assure enrollees
31 adequate access to health care providers, including
32 adequate numbers and types of providers;

33 (6) a satisfactory grievance procedure and
34 the ability to respond to enrollees' calls, questions,
35 and complaints; and

36 (7) financial capacity, either through
37 financial solvency standards as applied by the
38 commissioner or through appropriate reinsurance or
39 other risk-sharing mechanisms.

40 Revisor's Note

41 Subsection (b), V.T.I.C. Article 26.15, provides
42 that a cooperative may contract only with a small or
43 large employer carrier that demonstrates that "the
44 carrier is a health carrier or health maintenance
45 organization licensed and in good standing with the

1 [Texas Department of Insurance]." The revised law
2 omits the references to "health carrier" and "health
3 maintenance organization" as unnecessary. The
4 reference to "health maintenance organization" is
5 unnecessary because Subdivision (12), V.T.I.C.
6 Article 26.02, revised as Section 1501.002(6), defines
7 "health benefit plan issuer" to include a health
8 maintenance organization. The reference to "health
9 carrier" is unnecessary because Subdivision (16),
10 V.T.I.C. Article 26.02, revised as Section
11 1501.002(10), defines "large employer health benefit
12 plan issuer" and Subdivision (30), V.T.I.C. Article
13 26.02, as amended by Chapter 608, Acts of the 77th
14 Legislature, Regular Session, 2001, and Subdivision
15 (31), V.T.I.C. Article 26.02, as amended by Chapter
16 823, Acts of the 77th Legislature, Regular Session,
17 2001, revised as Section 1501.002(16), define "small
18 employer health benefit plan issuer" to mean a health
19 benefit plan issuer to the extent it offers health
20 benefit plans subject to this chapter. The revised law
21 omits the reference to "licensed" as unnecessary
22 because a health benefit plan issuer must be licensed
23 to be "in good standing" with the Texas Department of
24 Insurance.

25 Revised Law

26 Sec. 1501.062. COOPERATIVE NOT INSURER; AGENTS AND
27 ADMINISTRATORS. (a) A cooperative is not an insurer and the
28 employees of the cooperative are not required to be licensed under
29 Title 13.

30 (b) An agent or third-party administrator used and
31 compensated by a cooperative must be licensed as required by Title
32 13.

33 (c) An agent used and compensated by a cooperative may
34 market the products and services sponsored by the cooperative

1 without being appointed by each small employer health benefit plan
2 issuer participating in the cooperative. The agent may not market
3 any other product or service of a participating issuer that is not
4 sponsored by the cooperative unless the agent has been appointed by
5 that issuer. (V.T.I.C. Art. 26.16, Subsecs. (a), (c), (d).)

6 Source Law

7 Art. 26.16. (a) A cooperative is not an
8 insurer and the employees of the cooperative are not
9 required to be licensed under Section 15 or 15A, Texas
10 Health Maintenance Organization Act (Article 20A.15 or
11 20A.15A, Vernon's Texas Insurance Code), or Subchapter
12 A, Chapter 21, of this code.

13 (c) An agent or third-party administrator used
14 and compensated by the cooperative must be licensed as
15 required by Section 15 or 15A, Texas Health
16 Maintenance Organization Act (Article 20A.15 or
17 20A.15A, Vernon's Texas Insurance Code), or Subchapter
18 A, Chapter 21, of this code.

19 (d) A licensed agent used and compensated by the
20 cooperative need not be appointed by each small
21 employer carrier participating in the cooperative in
22 order to market the products and services sponsored by
23 the cooperative. However, a licensed agent may not
24 market any other non-sponsored product or service of a
25 participating small employer carrier without first
26 being appointed by the small employer carrier.

27 Revisor's Note

28 (1) Subsection (a), V.T.I.C. Article 26.16,
29 provides in part that employees of a purchasing
30 cooperative "are not required to be licensed under
31 Section 15 or 15A, Texas Health Maintenance
32 Organization Act (Article 20A.15 or 20A.15A, Vernon's
33 Texas Insurance Code), or Subchapter A, Chapter 21, of
34 this code." Subsection (c), V.T.I.C. Article 26.16,
35 provides that an agent or third-party administrator
36 used and compensated by a purchasing cooperative "must
37 be licensed as required by Section 15 or 15A, Texas
38 Health Maintenance Organization Act (Article 20A.15 or
39 20A.15A, Vernon's Texas Insurance Code), or Subchapter
40 A, Chapter 21, of this code." The revised law omits
41 the references to Articles 20A.15 and 20A.15A for the
42 reason stated in Revisor's Note (1) to Section
43 1501.002.

1 in the applicable service area before the fifth anniversary of the
2 date of the refusal.

3 (c) A small or large employer health benefit plan issuer is
4 not required to offer or issue a small or large employer health
5 benefit plan to:

6 (1) a small or large employer that is not located
7 within a geographic service area of the issuer;

8 (2) an employee of a small or large employer who
9 neither resides nor works in the geographic service area of the
10 issuer; or

11 (3) a small or large employer located within a
12 geographic service area of the issuer with respect to which area the
13 issuer demonstrates to the commissioner's satisfaction that the
14 issuer:

15 (A) reasonably anticipates that it will not have
16 the capacity to deliver services adequately because of obligations
17 to existing covered individuals; and

18 (B) is acting uniformly without regard to the
19 claims experience of the employer or any health status related
20 factor of employees, employees' dependents, or new employees or
21 dependents who may become eligible for the coverage.

22 (d) A small or large employer health benefit plan issuer
23 that is unable to offer coverage in a geographic service area in
24 accordance with a determination made by the commissioner under
25 Subsection (c)(3) may not offer a small or large employer benefit
26 plan, as applicable, in that service area before the 180th day after
27 the later of:

28 (1) the date the issuer refuses to offer coverage; or

29 (2) the date the issuer demonstrates to the
30 satisfaction of the commissioner that it has regained the capacity
31 to deliver services to small or large employers in the geographic
32 service area.

33 (e) If the commissioner determines that requiring the
34 acceptance of small or large employers under this chapter would

1 place a small or large employer health benefit plan issuer in a
2 financially impaired condition and that the issuer is acting
3 uniformly without regard to the claims experience of the small or
4 large employer or any health status related factors of eligible
5 employees, eligible employees' dependents, or new employees or
6 dependents who may become eligible for the coverage, the issuer may
7 not offer coverage to small or large employers until the later of:

8 (1) the 180th day after the date the commissioner
9 makes the determination; or

10 (2) the date the commissioner determines that
11 accepting small or large employers would not place the issuer in a
12 financially impaired condition. (V.T.I.C. Arts. 26.22, 26.85.)

13 Source Law

14 Art. 26.22. (a) A small employer carrier is
15 not required to offer or issue the small employer
16 health benefit plans:

17 (1) to a small employer that is not located
18 within a geographic service area of the small employer
19 carrier;

20 (2) to an employee of a small employer who
21 neither resides nor works in the geographic service
22 area of the small employer carrier; or

23 (3) to a small employer located within a
24 geographic service area with respect to which the
25 small employer carrier demonstrates to the
26 satisfaction of the commissioner that:

27 (A) the small employer carrier
28 reasonably anticipates that it will not have the
29 capacity to deliver services adequately because of
30 obligations to existing covered individuals; and

31 (B) the small employer carrier is
32 acting uniformly without regard to claims experience
33 of the employer or any health status related factor of
34 employees or dependents or new employees or dependents
35 who may become eligible for the coverage.

36 (b) A small employer carrier that refuses to
37 issue a small employer health benefit plan in a
38 geographic service area may not offer a health benefit
39 plan to a small employer in the affected service area
40 before the fifth anniversary of the date of the
41 refusal.

42 (c) A small employer carrier must file each of
43 its geographic service areas with the commissioner.
44 The commissioner may disapprove the use of a
45 geographic service area by a small employer carrier.

46 (d) A small employer carrier that is unable to
47 offer coverage in a geographic service area in
48 accordance with a determination made by the
49 commissioner under Subsection (a)(3) of this article
50 may not offer a small employer benefit plan in the
51 applicable geographic service area before the 180th
52 day after the later of:

53 (1) the date of the refusal; or

54 (2) the date the carrier demonstrates to

1 the satisfaction of the commissioner that it has
2 regained the capacity to deliver services to small
3 employers in the geographic service area.

4 (e) If the commissioner determines that
5 requiring the acceptance of small employers under this
6 subchapter would place a small employer carrier in a
7 financially impaired condition and that the small
8 employer carrier is acting uniformly without regard to
9 the claims experience of the small employer or any
10 health status related factors of eligible employees or
11 dependents or new employees or dependents who may
12 become eligible for the coverage, the small employer
13 carrier shall not offer coverage to small employers
14 until the later of:

15 (1) the 180th day after the date the
16 commissioner makes the determination; or

17 (2) the date the commissioner determines
18 that accepting small employers would not place the
19 small employer carrier in a financially impaired
20 condition.

21 Art. 26.85. (a) A large employer carrier is
22 not required to offer or issue the large employer
23 health benefit plans to:

24 (1) a large employer that is not located
25 within a geographic service area of the large employer
26 carrier;

27 (2) an employee of a large employer who
28 neither resides nor works in the geographic service
29 area of the large employer carrier; or

30 (3) a large employer located within a
31 geographic service area with respect to which the
32 large employer carrier demonstrates to the
33 satisfaction of the commissioner that the large
34 employer carrier:

35 (A) reasonably anticipates that it
36 will not have the capacity to deliver services
37 adequately because of obligations to existing covered
38 individuals; and

39 (B) is acting uniformly without
40 regard to the claims experience of the large employer
41 or any health status related factor of employees or
42 dependents or new employees or dependents who may
43 become eligible for the coverage.

44 (b) A large employer carrier that is unable to
45 offer coverage in a geographic service area in
46 accordance with a determination made by the
47 commissioner under Subsection (a)(3) of this article
48 may not offer large employer benefit plans in the
49 applicable service area before the 180th day after the
50 later of:

51 (1) the date of the refusal; or

52 (2) the date the carrier demonstrates to
53 the satisfaction of the commissioner that it has
54 regained the capacity to deliver services to large
55 employers in the geographic service area.

56 (c) If the commissioner determines that
57 requiring the acceptance of large employers under this
58 subchapter would place a large employer carrier in a
59 financially impaired condition and that the large
60 employer carrier is acting uniformly without regard to
61 claims experience of the large employer or any health
62 status related factors of employees or dependents or
63 new employees or dependents who may become eligible
64 for the coverage, the large employer carrier may not
65 offer coverage to large employers until the later of:

66 (1) the 180th day after the date the
67 commissioner makes the determination; or

1 (2) the date the commissioner determines
2 that accepting large employers would not place the
3 large employer carrier in a financially impaired
4 condition.

5 (d) A large employer carrier must file each of
6 its geographic service areas with the commissioner.
7 The commissioner may disapprove the use of a
8 geographic service area by a large employer carrier.

9 Revisor's Note

10 Subsection (e), V.T.I.C. Article 26.22, provides
11 that a small employer carrier is not required to offer
12 coverage to small employers if the commissioner of
13 insurance determines that accepting small employers
14 would place the carrier in a financially impaired
15 condition and that "the small employer carrier is
16 acting uniformly without regard to the claims
17 experience of the small employer or any health status
18 related factors of eligible employees or dependents or
19 new employees or dependents who may become eligible
20 for the coverage." Subsection (c), V.T.I.C. Article
21 26.85, provides that a large employer carrier is not
22 required to offer coverage to large employers if the
23 commissioner of insurance determines that accepting
24 large employers would place the carrier in a
25 financially impaired condition and that "the large
26 employer carrier is acting uniformly without regard to
27 claims experience of the large employer or any health
28 status related factors of employees or dependents or
29 new employees or dependents who may become eligible
30 for the coverage." The revised law refers to "health
31 status related factors of eligible employees, eligible
32 employees' dependents, or new employees or dependents
33 who may become eligible for coverage" because a small
34 or large health benefit plan issuer's consideration of
35 health status related factors is relevant only in
36 connection with employees and dependents who are
37 eligible for coverage.

1 Revised Law

2 Sec. 1501.102. PREEXISTING CONDITION PROVISION. (a) In
3 this section, "creditable coverage" has the meaning assigned by
4 Section 1205.004 and includes coverage provided under:

5 (1) a political subdivision health benefits risk pool;
6 and

7 (2) a short-term limited duration coverage plan.

8 (b) A preexisting condition provision in a small or large
9 employer health benefit plan may apply only to coverage for a
10 disease or condition for which medical advice, diagnosis, care, or
11 treatment was recommended or received during the six months before
12 the earlier of:

13 (1) the effective date of coverage; or

14 (2) the first day of the waiting period.

15 (c) A preexisting condition provision in a small or large
16 employer health benefit plan may not apply to expenses incurred on
17 or after the first anniversary of the initial effective date of
18 coverage of the enrollee, including a late enrollee.

19 (d) A preexisting condition provision in a small or large
20 employer health benefit plan may not apply to an individual who was
21 continuously covered for an aggregate period of 12 months under
22 creditable coverage that was in effect until a date not more than 63
23 days before the effective date of coverage under the plan,
24 excluding any waiting period.

25 (e) In determining whether a preexisting condition
26 provision applies to an individual covered by a small or large
27 employer health benefit plan, the plan issuer shall credit the time
28 the individual was covered under previous creditable coverage if
29 the previous coverage was in effect at any time during the 12 months
30 preceding the effective date of coverage under the plan. If the
31 previous coverage was issued under a health benefit plan, any
32 waiting period that applied before that coverage became effective
33 must also be credited against the preexisting condition provision
34 period. (V.T.I.C. Art. 26.02, Subdiv. (7); Art. 26.035;

1 Art. 26.49, Subsecs. (a), (b), (e), (f); Art. 26.90, Subsecs. (a),
2 (b), (e), (f).)

3 Source Law

4 Art. 26.02. In this chapter:

5 (7) "Creditable coverage" means coverage
6 described by Article 26.035 of this code.

7 Art. 26.035. (a) An individual's coverage is
8 creditable for purposes of this chapter if the
9 coverage is provided under:

10 (1) a self-funded or self-insured employee
11 welfare benefit plan that provides health benefits and
12 that is established in accordance with the Employee
13 Retirement Income Security Act of 1974 (29 U.S.C.
14 Section 1001 et seq.);

15 (2) a group health benefit plan provided
16 by a health insurance carrier or health maintenance
17 organization;

18 (3) an individual health insurance policy
19 or evidence of coverage;

20 (4) Part A or Part B of Title XVIII of the
21 Social Security Act (42 U.S.C. Section 1395c et seq.);

22 (5) Title XIX of the Social Security Act
23 (42 U.S.C. Section 1396 et seq.), other than coverage
24 consisting solely of benefits under Section 1928 of
25 that Act (42 U.S.C. Section 1396s);

26 (6) Chapter 55, Title 10, United States
27 Code (10 U.S.C. Section 1071 et seq.);

28 (7) a medical care program of the Indian
29 Health Service or of a tribal organization;

30 (8) a state or political subdivision
31 health benefits risk pool;

32 (9) a health plan offered under Chapter
33 89, Title 5, United States Code (5 U.S.C. Section 8901
34 et seq.);

35 (10) a public health plan as defined by
36 federal regulations;

37 (11) a health benefit plan under Section
38 5(e), Peace Corps Act (22 U.S.C. Section 2504(e)); or

39 (12) short term limited duration coverage.

40 (b) Creditable coverage does not include:

41 (1) accident-only or disability income
42 insurance, or a combination of accident-only and
43 disability income insurance;

44 (2) coverage issued as a supplement to
45 liability insurance;

46 (3) liability insurance, including
47 general liability insurance and automobile liability
48 insurance;

49 (4) workers' compensation or similar
50 insurance;

51 (5) automobile medical payment insurance;

52 (6) credit-only insurance;

53 (7) coverage for on-site medical clinics;

54 (8) other coverage that is:

55 (A) similar to the coverage described
56 by this subsection under which benefits for medical
57 care are secondary or incidental to other insurance
58 benefits; and

59 (B) specified in federal
60 regulations;

61 (9) coverage that provides limited-scope
62 dental or vision benefits;

1 (10) long-term care coverage or benefits,
2 nursing home care coverage or benefits, home health
3 care coverage or benefits, community-based care
4 coverage or benefits, or any combination of those
5 coverages or benefits;

6 (11) coverage that provides other limited
7 benefits specified by federal regulations;

8 (12) coverage for a specified disease or
9 illness;

10 (13) hospital indemnity or other fixed
11 indemnity insurance; or

12 (14) Medicare supplemental health
13 insurance as defined under Section 1882(g)(1), Social
14 Security Act (42 U.S.C. Section 1395ss), coverage
15 supplemental to the coverage provided under Chapter
16 55, Title 10, United States Code (10 U.S.C. Section
17 1071 et seq.), and similar supplemental coverage
18 provided under a group plan.

19 Art. 26.49. (a) A preexisting condition
20 provision in a small employer health benefit plan may
21 not apply to expenses incurred on or after the
22 expiration of the 12 months following the initial
23 effective date of coverage of the enrollee or late
24 enrollee.

25 (b) A preexisting condition provision in a small
26 employer health benefit plan may not apply to coverage
27 for a disease or condition other than a disease or
28 condition for which medical advice, diagnosis, care,
29 or treatment was recommended or received during the
30 six months before the earlier of:

31 (1) the effective date of coverage; or

32 (2) the first day of the waiting period.

33 (e) A preexisting condition provision in a small
34 employer health benefit plan may not apply to an
35 individual who was continuously covered for an
36 aggregate period of 12 months under creditable
37 coverage that was in effect up to a date not more than
38 63 days before the effective date of coverage under the
39 small employer health benefit plan, excluding any
40 waiting period.

41 (f) In determining whether a preexisting
42 condition provision applies to an individual covered
43 by a small employer health benefit plan, the small
44 employer carrier shall credit the time the individual
45 was covered under creditable coverage if the previous
46 coverage was in effect at any time during the 12 months
47 preceding the effective date of coverage under a small
48 employer health benefit plan. If the previous
49 coverage was issued under a health benefit plan, any
50 waiting period that applied before that coverage
51 became effective also shall be credited against the
52 preexisting condition provision period.

53 Art. 26.90. (a) A preexisting condition
54 provision in a large employer health benefit plan may
55 not apply to an expense incurred on or after the
56 expiration of the 12 months following the initial
57 effective date of coverage of the enrollee or late
58 enrollee.

59 (b) A preexisting condition provision in a large
60 employer health benefit plan may not apply to coverage
61 for a disease or condition other than a disease or
62 condition for which medical advice, diagnosis, care,
63 or treatment was recommended or received during the
64 six months before the earlier of:

65 (1) the effective date of coverage; or

1 (2) the first day of the waiting period.

2 (e) A preexisting condition provision in a large
3 employer health benefit plan shall not apply to an
4 individual who was continuously covered for an
5 aggregate period of 12 months under creditable
6 coverage that was in effect up to a date not more than
7 63 days before the effective date of coverage under the
8 large employer health benefit plan, excluding any
9 waiting period.

10 (f) In determining whether a preexisting
11 condition provision applies to an individual covered
12 by a large employer health benefit plan, the large
13 employer carrier shall credit the time the individual
14 was covered under creditable coverage if the previous
15 coverage was in effect at any time during the 12 months
16 preceding the effective date of coverage under a large
17 employer health benefit plan. If the previous
18 coverage was issued under a health benefit plan, any
19 waiting period shall also be credited to the
20 preexisting condition provision period.

21 Revisor's Note

22 Subdivision (7), V.T.I.C. Article 26.02, defines
23 "creditable coverage" to mean coverage "described by
24 Article 26.035 of this code." That definition of
25 "creditable coverage" was adopted by Chapter 955, Acts
26 of the 75th Legislature, Regular Session, 1997. A
27 substantially identical definition appeared three
28 times in Chapter 955, in sections amending Chapter 26,
29 Insurance Code, adding Article 21.52G, Insurance Code,
30 and adding Article 3.95-1.5, Insurance Code. The
31 intent of the legislature in enacting Chapter 955 was
32 to implement federal requirements on health insurance
33 portability and availability; the use of the same
34 definition in three different articles was to ensure
35 compliance with the federal requirements. The
36 definition contained in Article 21.52G, Insurance
37 Code, is revised in this code in Section 1205.004. The
38 only substantive differences between the two
39 provisions are that Subsection (a)(8), Article 26.035,
40 explicitly references coverage provided under a
41 political subdivision health benefits risk pool and
42 Subsection (a)(12), Article 26.035, explicitly
43 references coverage provided under short-term limited

1 duration coverage, neither of which is explicitly
2 referenced in Section 3, Article 21.52G. Therefore,
3 to avoid unnecessary duplication, the revised law
4 substitutes a cross-reference to Section 1205.004 for
5 the substance of Subdivision (7), Article 26.02, but
6 continues explicit references to a political
7 subdivision health benefits risk pool and to
8 short-term limited duration coverage.

9 Revised Law

10 Sec. 1501.103. TREATMENT OF CERTAIN CONDITIONS AS
11 PREEXISTING PROHIBITED. (a) A small or large employer health
12 benefit plan issuer may not treat genetic information as a
13 preexisting condition described by Section 1501.102(b) in the
14 absence of a diagnosis of the condition related to the information.

15 (b) A small or large employer health benefit plan issuer may
16 not treat pregnancy as a preexisting condition described by Section
17 1501.102(b). (V.T.I.C. Art. 26.49, Subsecs. (c), (d); Art. 26.90,
18 Subsecs. (c), (d).)

19 Source Law

20 [Art. 26.49]

21 (c) A small employer carrier shall not treat
22 genetic information as a preexisting condition
23 described by Subsection (b) of this article in the
24 absence of a diagnosis of the condition related to the
25 information.

26 (d) A small employer carrier shall not treat a
27 pregnancy as a preexisting condition described by
28 Subsection (b) of this article.

29 [Art. 26.90]

30 (c) A large employer carrier shall not treat
31 genetic information as a preexisting condition
32 described by Subsection (b) of this article in the
33 absence of a diagnosis of the condition related to the
34 information.

35 (d) A large employer carrier shall not treat a
36 pregnancy as a preexisting condition described by
37 Subsection (b) of this article.

38 Revised Law

39 Sec. 1501.104. AFFILIATION PERIOD. (a) In this section,
40 "affiliation period" means a period that, under a small or large
41 employer health benefit plan offered by a health maintenance
42 organization, must expire before the coverage becomes effective.

1 (b) A health maintenance organization may impose an
2 affiliation period if the period is applied uniformly without
3 regard to any health status related factor. The affiliation period
4 may not exceed:

5 (1) two months for an enrollee, other than a late
6 enrollee; or

7 (2) 90 days for a late enrollee.

8 (c) An affiliation period under a small or large employer
9 health benefit plan must run concurrently with any applicable
10 waiting period under the plan. A health maintenance organization
11 must credit an affiliation period against any preexisting condition
12 provision period.

13 (d) During an affiliation period, a health maintenance
14 organization:

15 (1) is not required to provide health care services or
16 benefits to the participant or beneficiary; and

17 (2) may not charge a premium to the participant or
18 beneficiary.

19 (e) A health maintenance organization may use an
20 alternative method approved by the commissioner to address adverse
21 selection. (V.T.I.C. Art. 26.02, Subdiv. (1); Art. 26.49, Subsec.
22 (g); Art. 26.90, Subsec. (g).)

23 Source Law

24 Art. 26.02. In this chapter:

25 (1) "Affiliation period" means a period
26 that, under the terms of the coverage offered by a
27 health maintenance organization, must expire before
28 the coverage becomes effective. During an affiliation
29 period:

30 (A) a health maintenance
31 organization is not required to provide health care
32 services or benefits to the participant or
33 beneficiary; and

34 (B) a premium may not be charged to
35 the participant or beneficiary.

36 [Art. 26.49]

37 (g) A health maintenance organization may
38 impose an affiliation period if the period is applied
39 uniformly without regard to any health status related
40 factor. The affiliation period shall not exceed two
41 months for an enrollee, other than a late enrollee, and
42 shall not exceed 90 days for a late enrollee. An
43 affiliation period under a plan shall run concurrently

1 with any applicable waiting period under the plan. The
2 health maintenance organization must credit an
3 affiliation period to any preexisting condition
4 provision period. A health maintenance organization
5 may use an alternative method approved by the
6 commissioner to address adverse selection.

7 [Art. 26.90]

8 (g) A health maintenance organization may
9 impose an affiliation period if the period is applied
10 uniformly without regard to any health status related
11 factor. The affiliation period shall not exceed two
12 months for an enrollee, other than a late enrollee, and
13 shall not exceed 90 days for a late enrollee. An
14 affiliation period under a plan shall run concurrently
15 with any applicable waiting period under the plan. The
16 health maintenance organization must credit an
17 affiliation period to any preexisting condition
18 provision period. A health maintenance organization
19 may use an alternative method approved by the
20 commissioner to address adverse selection.

21 Revised Law

22 Sec. 1501.105. WAITING PERIOD PERMITTED. Sections
23 1501.102-1501.104 do not preclude application of a waiting period
24 that applies to all new enrollees under a small or large employer
25 health benefit plan. (V.T.I.C. Art. 26.49, Subsec. (h);
26 Art. 26.90, Subsec. (h).)

27 Source Law

28 [Art. 26.49]

29 (h) This article does not preclude application
30 of any waiting period applicable to all new enrollees
31 under the health benefit plan.

32 [Art. 26.90]

33 (h) This article does not preclude application
34 of any waiting period applicable to all new enrollees
35 under the health benefit plan.

36 Revised Law

37 Sec. 1501.106. CERTAIN LIMITATIONS OR EXCLUSIONS OF
38 COVERAGE PROHIBITED. (a) A small or large employer health
39 benefit plan may not limit or exclude, by use of a rider or
40 amendment applicable to a specific individual, coverage by type of
41 illness, treatment, medical condition, or accident.

42 (b) This section does not preclude a small or large employer
43 health benefit plan from limiting or excluding coverage for a
44 preexisting condition in accordance with Section 1501.102.
45 (V.T.I.C. Art. 26.21, Subsec. (m); Art. 26.83, Subsec. (m).)

1 Source Law

2 [Art. 26.21]

3 (m) A small employer health benefit plan issued
4 by a small employer carrier may not limit or exclude,
5 by use of a rider or amendment applicable to a specific
6 individual, coverage by type of illness, treatment,
7 medical condition, or accident, except for preexisting
8 conditions or diseases as permitted under Article
9 26.49 of this code.

10 [Art. 26.83]

11 (m) A large employer health benefit plan may
12 not, by use of a rider or amendment applicable to a
13 specific individual, limit or exclude coverage by type
14 of illness, treatment, medical condition, or accident,
15 except for a preexisting condition permitted under
16 Article 26.90 of this code.

17 Revisor's Note

18 Subsection (m), V.T.I.C. Article 26.21, refers to
19 "preexisting conditions or diseases." The reference
20 to "diseases" is omitted from the revised law because
21 the concept is included within the definition of
22 "preexisting condition provision" under Subdivision
23 (24), V.T.I.C. Article 26.02, revised as Section
24 1501.002(12).

25 Revised Law

26 Sec. 1501.107. DISCOUNTS, REBATES, AND REDUCTIONS. (a) A
27 small or large employer health benefit plan issuer may establish
28 premium discounts, rebates, or a reduction in otherwise applicable
29 copayments or deductibles in return for adherence to programs of
30 health promotion and disease prevention.

31 (b) A discount, rebate, or reduction established under this
32 section does not violate Section 541.056(a). (V.T.I.C. Art. 26.33,
33 Subsec. (e); Art. 26.89, Subsec. (b).)

34 Source Law

35 [Art. 26.33]

36 (e) A small employer carrier may establish
37 premium discounts, rebates, or a reduction in
38 otherwise applicable copayments or deductibles in
39 return for adherence to programs of health promotion
40 and disease prevention. A discount, rebate, or
41 reduction established under this subsection does not
42 violate Section 4(8), Article 21.21, of this code.

43 [Art. 26.89]

44 (b) A large employer carrier may establish
45 premium discounts, rebates, or a reduction in
46 otherwise applicable copayments or deductibles in

1 return for adherence to programs of health promotion
2 and disease prevention. A discount, rebate, or
3 reduction established under this subsection does not
4 violate Section 4(8), Article 21.21, of this code.

5 Revised Law

6 Sec. 1501.108. RENEWABILITY OF COVERAGE; CANCELLATION. (a)
7 Except as provided by Section 1501.109, a small or large employer
8 health benefit plan issuer shall renew the small or large employer
9 health benefit plan for any covered small or large employer, as
10 applicable, at the employer's option, unless:

11 (1) a premium has not been paid as required by the
12 terms of the plan;

13 (2) the employer has committed fraud or has
14 intentionally misrepresented a material fact;

15 (3) the employer has not complied with the terms of the
16 plan;

17 (4) no enrollee in the plan resides or works in the
18 geographic service area of the small or large employer health
19 benefit plan issuer or in the area for which the issuer is
20 authorized to do business; or

21 (5) membership of the employer in an association
22 terminates, but only if coverage is terminated uniformly without
23 regard to a health status related factor of a covered individual.

24 (b) A small or large employer health benefit plan issuer may
25 refuse to renew the coverage of a covered employee or dependent for
26 fraud or intentional misrepresentation of a material fact by that
27 individual.

28 (c) A small or large employer health benefit plan issuer may
29 not cancel a small or large employer health benefit plan except for
30 a reason specified for refusal to renew under Subsection (a). A
31 small or large employer health benefit plan issuer may not cancel
32 the coverage of a covered employee or dependent except for a reason
33 specified for refusal to renew under Subsection (b). (V.T.I.C.
34 Arts. 26.23, 26.86.)

35 Source Law

36 Art. 26.23. (a) Except as provided by Article

1 26.24 of this code, a small employer carrier shall
2 renew the small employer health benefit plan for any
3 covered small employer, at the option of the small
4 employer, unless:

5 (1) a premium has not been paid as required
6 by the terms of the plan;

7 (2) the small employer has committed fraud
8 or intentional misrepresentation of a material fact;

9 (3) the small employer has not complied
10 with the terms of the health benefit plan;

11 (4) no enrollee in connection with the
12 plan resides or works in the service area of the small
13 employer carrier or in the area for which the small
14 employer carrier is authorized to do business; or

15 (5) membership of an employer in an
16 association terminates, but only if coverage is
17 terminated uniformly without regard to a health status
18 related factor of a covered individual.

19 (b) A small employer carrier may refuse to renew
20 the coverage of a covered employee or dependent for
21 fraud or intentional misrepresentation of a material
22 fact by that individual.

23 (c) A small employer carrier may not cancel a
24 small employer health benefit plan except for the
25 reasons specified for refusal to renew under
26 Subsection (a) of this article. A small employer
27 carrier may not cancel the coverage of a covered
28 employee or dependent except for the reasons specified
29 for refusal to renew under Subsection (b) of this
30 article.

31 Art. 26.86. (a) Except as provided by Article
32 26.87 of this code, a large employer carrier shall
33 renew the large employer health benefit plans for a
34 covered large employer, at the option of the large
35 employer, unless:

36 (1) a premium has not been paid as required
37 by the terms of the plan;

38 (2) the large employer has committed fraud
39 or intentional misrepresentation of a material fact;

40 (3) the large employer has not complied
41 with the terms of the health benefit plan;

42 (4) no enrollee in connection with the
43 plan resides or works in the service area of the large
44 employer carrier or in the area for which the large
45 employer carrier is authorized to do business; or

46 (5) membership of an employer in an
47 association terminates, but only if coverage is
48 terminated uniformly without regard to a health status
49 related factor of a covered individual.

50 (b) A large employer carrier may refuse to renew
51 the coverage of an eligible employee or dependent for
52 fraud or intentional misrepresentation of a material
53 fact by that individual.

54 (c) A large employer carrier may not cancel a
55 large employer health benefit plan except for the
56 reasons specified for refusal to renew under
57 Subsection (a) of this article. A large employer
58 carrier may not cancel the coverage of an eligible
59 employee or dependent except for the reasons specified
60 for refusal to renew under Subsection (b) of this
61 article.

62 Revisor's Note

63 Subsection (b), V.T.I.C. Article 26.23, provides
64 that a small employer carrier may refuse to renew the

1 coverage of "a covered employee or dependent" for
2 fraud or intentional misrepresentation. Subsection
3 (b), V.T.I.C. Article 26.86, provides that a large
4 employer carrier may refuse to renew the coverage of
5 "an eligible employee or dependent" for fraud or
6 intentional misrepresentation. Similarly, Subsection
7 (c), V.T.I.C. Article 26.23, provides that a small
8 employer carrier may not cancel the coverage of "a
9 covered employee or dependent" except for the reasons
10 specified for refusal to renew under Subsection (b),
11 and Subsection (c), V.T.I.C. Article 26.86, provides
12 that a large employer carrier may not cancel the
13 coverage of "an eligible employee or dependent" except
14 for the reasons specified for refusal to renew under
15 Subsection (b). The revised law refers only to "a
16 covered employee or dependent" because before a small
17 or large employer health benefit plan issuer may
18 refuse to renew or cancel an employee's or dependent's
19 coverage, the employee or dependent must be covered.

20 Revised Law

21 Sec. 1501.109. REFUSAL TO RENEW; DISCONTINUATION OF
22 COVERAGE. (a) A small or large employer health benefit plan
23 issuer may elect to refuse to renew all small or large employer
24 health benefit plans delivered or issued for delivery by the issuer
25 in this state or in a geographic service area approved under Section
26 1501.101. The issuer shall notify:

27 (1) the commissioner of the election not later than
28 the 180th day before the date coverage under the first plan
29 terminates under this subsection; and

30 (2) each affected covered small or large employer not
31 later than the 180th day before the date coverage terminates for
32 that employer.

33 (b) A small employer health benefit plan issuer that elects
34 under this section to refuse to renew all small employer health

1 benefit plans in this state or in an approved geographic service
2 area may not write a new small employer health benefit plan in this
3 state or in the geographic service area, as applicable, before the
4 fifth anniversary of the date notice is provided to the
5 commissioner under Subsection (a).

6 (c) A large employer health benefit plan issuer that elects
7 under this section to refuse to renew all large employer health
8 benefit plans in this state or in an approved geographic service
9 area may not write a new large employer health benefit plan in this
10 state or in the geographic service area, as applicable, before the
11 fifth anniversary of the date notice is provided to the
12 commissioner under Subsection (a).

13 (d) A small or large employer health benefit plan issuer may
14 elect to discontinue a particular type of small or large employer
15 coverage only if the issuer:

16 (1) before the 90th day preceding the date of the
17 discontinuation of the coverage:

18 (A) provides notice of the discontinuation to the
19 employer and the commissioner; and

20 (B) offers to each employer the option to
21 purchase other small or large employer coverage offered by the
22 issuer at the time of the discontinuation; and

23 (2) acts uniformly without regard to the claims
24 experience of the employer or any health status related factors of
25 eligible employees, eligible employees' dependents, or new
26 employees or dependents who may become eligible for the coverage.
27 (V.T.I.C. Arts. 26.24, 26.87.)

28 Source Law

29 Art. 26.24. (a) A small employer carrier may
30 elect to refuse to renew all small employer health
31 benefit plans delivered or issued for delivery by the
32 small employer carrier in this state or in a geographic
33 service area approved under Article 26.22 of this
34 code. The small employer carrier shall notify the
35 commissioner of the election not later than the 180th
36 day before the date coverage under the first small
37 employer health benefit plan terminates under this
38 subsection.

39 (b) The small employer carrier must notify each

1 affected covered small employer not later than the
2 180th day before the date on which coverage terminates
3 for that small employer.

4 (c) A small employer carrier that elects under
5 Subsection (a) of this article to refuse to renew all
6 small employer health benefit plans in this state or in
7 an approved geographic service area may not write a new
8 small employer health benefit plan in this state or in
9 the geographic service area, as applicable, before the
10 fifth anniversary of the date of notice to the
11 commissioner under Subsection (a) of this article.

12 (d) A small employer carrier may elect to
13 discontinue a particular type of small employer
14 coverage only if the small employer carrier:

15 (1) before the 90th day preceding the date
16 of the discontinuation of the coverage:

17 (A) provides notice of the
18 discontinuation to the employer and the commissioner;
19 and

20 (B) offers to each employer the
21 option to purchase other small employer coverage
22 offered by the small employer carrier at the time of
23 the discontinuation; and

24 (2) acts uniformly without regard to the
25 claims experience of the employer or any health status
26 related factors of employees or dependents or new
27 employees or dependents who may become eligible for
28 the coverage.

29 Art. 26.87. (a) A large employer carrier may
30 elect to refuse to renew all large employer health
31 benefit plans delivered or issued for delivery by the
32 large employer carrier in this state or in a geographic
33 service area approved under Article 26.85 of this
34 code. The large employer carrier shall notify the
35 commissioner of the election not later than the 180th
36 day before the date coverage under the first large
37 employer health benefit plan terminates under this
38 subsection.

39 (b) The large employer carrier shall notify each
40 affected covered large employer not later than the
41 180th day before the date on which coverage terminates
42 for that large employer.

43 (c) A large employer carrier that elects under
44 Subsection (a) of this article to refuse to renew all
45 large employer health benefit plans in this state or in
46 an approved geographic service area may not write a new
47 large employer health benefit plan in this state or in
48 the geographic service area, as applicable, before the
49 fifth anniversary of the date on which notice is
50 delivered to the commissioner under Subsection (a) of
51 this article.

52 (d) A large employer carrier may elect to
53 discontinue a particular type of large employer
54 coverage only if the large employer carrier:

55 (1) before the 90th day preceding the date
56 of the discontinuation of the coverage:

57 (A) provides notice of the
58 discontinuation to the employer and the commissioner;
59 and

60 (B) offers to each employer the
61 option to purchase other large employer coverage
62 offered by the large employer carrier at the time of
63 the discontinuation; and

64 (2) acts uniformly without regard to the
65 claims experience of the employer or any health status
66 related factors of employees or dependents or new
67 employees or dependents who may become eligible for

1 the coverage.

2 Revised Law

3 Sec. 1501.110. NOTICE TO COVERED PERSONS. (a) A small or
4 large employer health benefit plan issuer that cancels or refuses
5 to renew coverage under a small or large employer health benefit
6 plan under Section 1501.108 or 1501.109 shall, not later than the
7 30th day before the date termination of coverage is effective,
8 notify the small or large employer of the cancellation of or refusal
9 to renew coverage. The employer is responsible for notifying
10 enrollees in the plan of the cancellation of or refusal to renew
11 coverage.

12 (b) The notice provided to a small or large employer by a
13 small or large employer health benefit plan issuer under this
14 section is in addition to any other notice required by Section
15 1501.109. (V.T.I.C. Arts. 26.25, 26.88.)

16 Source Law

17 Art. 26.25. (a) Not later than the 30th day
18 before the date on which termination of coverage is
19 effective, a small employer carrier that cancels or
20 refuses to renew coverage under a small employer
21 health benefit plan under Article 26.23 or 26.24 of
22 this code shall notify the small employer of the
23 cancellation or refusal to renew. It is the
24 responsibility of the small employer to notify
25 enrollees of the cancellation or refusal to renew the
26 coverage.

27 (b) The notice provided to a small employer by a
28 small employer carrier under this article is in
29 addition to any other notice required by Article 26.23
30 or 26.24 of this code.

31 Art. 26.88. (a) Not later than the 30th day
32 before the date on which termination of coverage is
33 effective, a large employer carrier that cancels or
34 refuses to renew coverage under a large employer
35 health benefit plan under Article 26.86 or 26.87 of
36 this code shall notify the large employer of the
37 cancellation or refusal to renew. It is the
38 responsibility of the large employer to notify
39 enrollees of the cancellation or refusal to renew the
40 coverage.

41 (b) The notice provided to a large employer by a
42 large employer carrier under this article is in
43 addition to any other notice required by Article 26.86
44 or 26.87 of this code.

45 Revisor's Note

46 Subsection (b), V.T.I.C. Article 26.25, refers to
47 "notice required by Article 26.23 or 26.24 of this

1 code." Subsection (b), V.T.I.C. Article 26.88, refers
2 to "notice required by Article 26.86 or 26.87 of this
3 code." Articles 26.23 and 26.86 are revised as Section
4 1501.108, and Articles 26.24 and 26.87 are revised as
5 Section 1501.109. The revised law omits the
6 references to Articles 26.23 and 26.86 as unnecessary
7 because those articles do not require a small or large
8 employer health benefit plan issuer, respectively, to
9 provide any notice.

10 Revised Law

11 Sec. 1501.111. WRITTEN STATEMENT OF DENIAL, CANCELLATION,
12 OR REFUSAL TO RENEW REQUIRED. Denial by a small or large employer
13 health benefit plan issuer of an application from a small or large
14 employer for coverage from the issuer or cancellation of or refusal
15 to renew coverage by a small or large employer health benefit plan
16 issuer must:

17 (1) be in writing; and

18 (2) state the reason or reasons for the denial,
19 cancellation, or refusal to renew. (V.T.I.C. Arts. 26.74, 26.94.)

20 Source Law

21 Art. 26.74. Denial by a small employer carrier
22 of an application for coverage from a small employer or
23 a cancellation or refusal to renew must be in writing
24 and must state the reason or reasons for the denial,
25 cancellation, or refusal.

26 Art. 26.94. Denial by a large employer carrier
27 of an application for coverage from a large employer
28 carrier or cancellation or refusal to renew must be in
29 writing and must state the reason or reasons for the
30 denial, cancellation, or refusal.

31 [Sections 1501.112-1501.150 reserved for expansion]

32 SUBCHAPTER D. GUARANTEED ISSUE OF SMALL EMPLOYER HEALTH BENEFIT 33 PLANS; CONTINUATION OF COVERAGE

34 Revised Law

35 Sec. 1501.151. GUARANTEED ISSUE. (a) A small employer
36 health benefit plan issuer shall issue the small employer health
37 benefit plan chosen by the small employer to each small employer
38 that elects to be covered under the plan and agrees to satisfy the

1 other requirements of the plan.

2 (b) A small employer health benefit plan issuer shall
3 provide small employer health benefit plans without regard to
4 health status related factors.

5 (c) This chapter does not require a small employer to
6 purchase health coverage for the employer's employees. (V.T.I.C.
7 Art. 26.21, Subsecs. (a), (c) (part).)

8 Source Law

9 Art. 26.21. (a) Each small employer carrier
10 shall provide the small employer health benefit plans
11 without regard to health status related factors. Each
12 small employer carrier shall issue the plan chosen by
13 the small employer to each small employer that elects
14 to be covered under that plan and agrees to satisfy the
15 other requirements of the plan.

16 (c) . . . This chapter does not require a small
17 employer to purchase health insurance coverage for the
18 employer's employees.

19 Revised Law

20 Sec. 1501.152. EXCLUSION OF ELIGIBLE EMPLOYEE OR DEPENDENT
21 PROHIBITED. A small employer health benefit plan issuer may not
22 exclude an eligible employee or dependent, including a late
23 enrollee, who would otherwise be covered under a small employer
24 group. (V.T.I.C. Art. 26.21, Subsec. (1).)

25 Source Law

26 (1) A small employer carrier may not exclude any
27 eligible employee or dependent, including a late
28 enrollee, who would otherwise be covered under a small
29 employer group.

30 Revised Law

31 Sec. 1501.153. EMPLOYER CONTRIBUTION. (a) This chapter
32 does not require a small employer to make an employer contribution
33 to the premium paid to a small employer health benefit plan issuer,
34 but the issuer may require an employer contribution in accordance
35 with the issuer's usual and customary practices applicable to the
36 issuer's employer group health benefit plans in this state. The
37 issuer shall apply the employer contribution level uniformly to
38 each small employer offered or issued coverage by the issuer in this
39 state.

1 (b) If two or more small employer health benefit plan
2 issuers participate in a purchasing cooperative established under
3 Section 1501.056, each participating issuer may use the employer
4 contribution requirement established by the cooperative for
5 policies marketed by the cooperative.

6 (c) A small employer that elects to make an employer
7 contribution to the premium paid to a small employer health benefit
8 plan issuer is not required to pay any amount with respect to an
9 employee who elects not to be covered.

10 (d) A small employer may elect to pay the premium for
11 additional coverage. (V.T.I.C. Art. 26.21, Subsecs. (b) (part),
12 (c) (part).)

13 Source Law

14 (b) This article does not impose a statutory
15 mandate of an employer contribution to the premium
16 paid to the small employer carrier. However, the small
17 employer carrier may require an employer contribution
18 in accordance with the carrier's usual and customary
19 practices on all employer group health insurance plans
20 in this state. The premium contribution level shall be
21 applied uniformly to each small employer offered or
22 issued coverage by the small employer carrier in this
23 state. If two or more small employer carriers
24 participate in a purchasing cooperative established
25 under Article 26.14 of this code, the carrier may use
26 the contribution requirement established by the
27 purchasing cooperative for policies marketed by the
28 cooperative. . . .

29 (c) . . . A small employer who elects to make
30 contributions for payment of the premium is not
31 required to pay any amount with respect to an employee
32 who elects not to be covered. The small employer may
33 elect to pay the premium cost for additional
34 coverage. . . .

35 Revised Law

36 Sec. 1501.154. MINIMUM PARTICIPATION REQUIREMENT. (a)
37 Except as provided by Section 1501.155, coverage is available under
38 a small employer health benefit plan if at least 75 percent of a
39 small employer's eligible employees elect to participate in the
40 plan.

41 (b) If a small employer offers multiple health benefit
42 plans, the collective participation in those plans must be at
43 least:

44 (1) 75 percent of the employer's eligible employees;

1 or

2 (2) if applicable, the lower participation level
3 offered by the small employer health benefit plan issuer under
4 Section 1501.155.

5 (c) A small employer health benefit plan issuer may elect
6 not to offer a health benefit plan to a small employer that offers
7 multiple health benefit plans if:

8 (1) the plans are provided by more than one issuer;

9 (2) the issuer would have less than 75 percent of the
10 employer's eligible employees enrolled in the issuer's plan; and

11 (3) the issuer's plan is not provided through a
12 purchasing cooperative. (V.T.I.C. Art. 26.21, Subsecs. (b)
13 (part), (c) (part).)

14 Source Law

15 (b) . . . Coverage is available under a small
16 employer health benefit plan if at least 75 percent of
17 a small employer's eligible employees elect to be
18 covered.

19 (c) If a small employer offers multiple health
20 benefit plans, the collective enrollment of all of
21 those plans must be at least 75 percent of the small
22 employer's eligible employees or, if applicable, the
23 lower participation level offered by the small
24 employer carrier under Subsection (d) of this article.
25 A small employer carrier may elect not to offer health
26 benefit plans to a small employer who offers multiple
27 health benefit plans if such plans are to be provided
28 by more than one carrier and the small employer carrier
29 would have less than 75 percent of the small employer's
30 eligible employees enrolled in the small employer
31 carrier's health benefit plan unless the coverage is
32 provided through a purchasing cooperative. . . .

33 Revised Law

34 Sec. 1501.155. EXCEPTION TO MINIMUM PARTICIPATION
35 REQUIREMENT. (a) A small employer health benefit plan issuer may
36 offer a small employer health benefit plan to a small employer with
37 a participation level of less than 75 percent of the employer's
38 eligible employees if the issuer permits the same qualifying
39 participation level for each small employer health benefit plan
40 offered by the issuer in this state.

41 (b) A small employer health benefit plan issuer may offer a
42 small employer health benefit plan to a small employer even if the

1 employer's participation level is less than the issuer's qualifying
2 participation level established in accordance with Subsection (a)
3 if:

4 (1) the employer obtains a written waiver from each
5 eligible employee who declines coverage under a health benefit plan
6 offered to the employer stating that the employee was not induced or
7 pressured to decline coverage because of the employee's risk
8 characteristics; and

9 (2) the issuer accepts or rejects the entire group of
10 eligible employees who choose to participate and excludes only
11 those employees who have declined coverage.

12 (c) A small employer health benefit plan issuer may
13 underwrite the group of eligible employees who do not decline
14 coverage under Subsection (b).

15 (d) A small employer health benefit plan issuer may not
16 provide coverage to a small employer or the employer's employees
17 under Subsection (b) if the issuer or an agent for the issuer knows
18 that the employer has induced or pressured an eligible employee or a
19 dependent of the employee to decline coverage because of the
20 individual's risk characteristics.

21 (e) A small employer health benefit plan issuer, a small
22 employer, or an agent may not use the exception provided by
23 Subsection (b) to circumvent the requirements of this chapter.
24 (V.T.I.C. Art. 26.21, Subsecs. (d), (e), (f).)

25 Source Law

26 (d) A small employer carrier may offer small
27 employer health benefit plans to a small employer even
28 if less than 75 percent of the eligible employees of
29 that employer elect to be covered if the small employer
30 carrier permits the same percentage of participation
31 as a qualifying percentage for each small employer
32 benefit plan offered by that carrier in this state. A
33 small employer carrier may offer small employer health
34 benefit plans to a small employer even if the
35 employer's participation level is less than the small
36 employer carrier's qualifying participation level
37 established in accordance with this article if:

38 (1) the small employer obtains a written
39 waiver for each eligible employee who declines
40 coverage under a health plan offered to the small
41 employer ensuring that the eligible employee was not
42 induced or pressured into declining coverage because

1 of the employee's risk characteristics; and

2 (2) the small employer carrier accepts or
3 rejects the entire group of eligible employees that
4 choose to participate and excludes only those
5 employees that have declined coverage, provided that
6 the carrier may underwrite the group of eligible
7 employees that do not decline coverage.

8 (e) A small employer carrier may not provide
9 coverage to a small employer or the employees of a
10 small employer under Subsection (d)(2) of this article
11 if the health carrier or an agent for the health
12 carrier knows that the small employer has induced or
13 pressured an eligible employee or the employee's
14 dependents to decline coverage because of an
15 individual's risk characteristics.

16 (f) A small employer carrier, an employer, or an
17 agent may not use the provisions of Subsection (d)(2)
18 of this article to circumvent the requirements of this
19 chapter.

20 Revised Law

21 Sec. 1501.156. EMPLOYEE ENROLLMENT; WAITING PERIOD. (a)

22 The initial enrollment period under a small employer health benefit
23 plan for employees and dependents must be at least 31 days, with a
24 31-day open enrollment period provided annually.

25 (b) A small employer may establish a waiting period not to
26 exceed 90 days from the first day of employment.

27 (c) A small employer health benefit plan issuer may not deny
28 coverage to a new employee of a covered small employer or the
29 employee's dependents if the issuer receives an application for
30 coverage not later than the 31st day after the date employment
31 begins or on completion of a waiting period established under
32 Subsection (b).

33 (d) A small employer health benefit plan issuer may deny
34 coverage to a late enrollee until the next annual open enrollment
35 period and may subject the enrollee to a one-year preexisting
36 condition provision as described by Section 1501.102. The period
37 during which the preexisting condition provision applies may not
38 exceed 18 months from the date of the initial application.

39 (V.T.I.C. Art. 26.21, Subsecs. (h), (i), (j), (k).)

40 Source Law

41 (h) The initial enrollment period for the
42 employees and their dependents must be at least 31
43 days, with a 31-day open enrollment period provided
44 annually.

45 (i) A small employer may establish a waiting
46 period during which a new employee is not eligible for

1 coverage. A waiting period established as provided by
2 this subsection may not exceed 90 days from the first
3 day of employment.

4 (j) A new employee of a covered small employer
5 and the dependents of that employee may not be denied
6 coverage if the application for coverage is received
7 by the small employer carrier not later than the 31st
8 day after the date on which the employment begins or on
9 completion of a waiting period established by the
10 employer under Subsection (i) of this article.

11 (k) A late enrollee may be excluded from
12 coverage until the next annual open enrollment period
13 and may be subject to a 12-month preexisting condition
14 provision as described by Article 26.49 of this code.
15 The period during which a preexisting condition
16 provision is imposed may not exceed 18 months from the
17 date of the initial application.

18 Revisor's Note

19 Subsection (i), V.T.I.C. Article 26.21, provides
20 that a small employer may establish a waiting period
21 "during which a new employee is not eligible for
22 coverage." The revised law omits the quoted language
23 as unnecessary because Subdivision (33), V.T.I.C.
24 Article 26.02, as amended by Chapter 608, Acts of the
25 77th Legislature, Regular Session, 2001, and
26 Subdivision (34), V.T.I.C. Article 26.02, as amended
27 by Chapter 823, Acts of the 77th Legislature, Regular
28 Session, 2001, revised as Section 1501.002(17), define
29 "waiting period" as "a period established by an
30 employer that must pass before an individual who is a
31 potential enrollee in a health benefit plan is
32 eligible to be covered for benefits."

33 Revised Law

34 Sec. 1501.157. COVERAGE FOR NEWBORN CHILDREN. (a) A
35 small employer health benefit plan may not limit or exclude initial
36 coverage of a newborn child of a covered employee.

37 (b) Coverage of a newborn child of a covered employee under
38 this section ends on the 32nd day after the date of the child's
39 birth unless, not later than the 31st day after the date of birth,
40 the small employer health benefit plan issuer receives:

41 (1) notice of the birth; and

42 (2) any required additional premium. (V.T.I.C. Art.

1 26.21, Subsec. (n).)

2 Source Law

3 (n) A small employer health benefit plan may not
4 limit or exclude initial coverage of a newborn child of
5 a covered employee. Any coverage of a newborn child of
6 an employee under this subsection terminates on the
7 32nd day after the date of the birth of the child
8 unless notification of the birth and any required
9 additional premium are received by the small employer
10 carrier not later than the 31st day after the date of
11 birth.

12 Revised Law

13 Sec. 1501.158. COVERAGE FOR ADOPTED CHILDREN. (a) A
14 small employer health benefit plan may not limit or exclude initial
15 coverage of an adopted child of an insured. A child is considered
16 to be the child of an insured if the insured is a party to a suit in
17 which the insured seeks to adopt the child.

18 (b) An adopted child of an insured may be enrolled, at the
19 insured's option, not later than the 31st day after:

20 (1) the date the insured becomes a party to a suit in
21 which the insured seeks to adopt the child; or

22 (2) the date the adoption becomes final.

23 (c) Coverage of an adopted child of an insured under this
24 section ends unless the small employer health benefit plan issuer
25 receives notice of the adoption and any required additional premium
26 not later than the 31st day after:

27 (1) the date the insured becomes a party to a suit in
28 which the insured seeks to adopt the child; or

29 (2) the date the adoption becomes final. (V.T.I.C.
30 Art. 26.21A.)

31 Source Law

32 Art. 26.21A. (a) A small employer health
33 benefit plan may not limit or exclude initial coverage
34 of an adopted child of an insured. A child is
35 considered to be the child of an insured if the insured
36 is a party in a suit in which the adoption of the child
37 by the insured is sought.

38 (b) The adopted child of an insured may be
39 enrolled, at the option of the insured, within either:

40 (1) 31 days after the insured is a party in
41 a suit for adoption; or

42 (2) 31 days of the date the adoption is
43 final.

44 (c) Coverage of an adopted child of an employee

1 under this article terminates unless notification of
2 the adoption and any required additional premiums are
3 received by the small employer carrier not later than
4 either:

5 (1) the 31st day after the insured becomes
6 a party in a suit in which the adoption of the child by
7 the insured is sought; or

8 (2) the 31st day after the date of the
9 adoption.

10 Revised Law

11 Sec. 1501.159. CONTINUATION OF COVERAGE FOR CERTAIN
12 DEPENDENTS. An employee's dependent may choose to continue
13 coverage under a small employer health benefit plan if:

14 (1) the dependent:

15 (A) is under one year of age; or

16 (B) has been covered by the small employer under
17 a plan for at least one year;

18 (2) the dependent loses eligibility for coverage
19 because of the death, divorce, or retirement of the employee, as
20 provided by Subchapter G, Chapter 1251; and

21 (3) the Consolidated Omnibus Budget Reconciliation
22 Act of 1985 (Pub. L. No. 99-272) does not require continuation or
23 conversion coverage for dependents of an employee. (V.T.I.C. Art.
24 26.21, Subsec. (o).)

25 Source Law

26 (o) If the Consolidated Omnibus Budget
27 Reconciliation Act of 1985 (Pub. L. No. 99-272, 100
28 Stat. 222) does not require continuation or conversion
29 coverage for dependents of an employee, a dependent
30 who has been covered by that small employer for at
31 least one year or is under one year of age may elect to
32 continue coverage under a small employer health
33 benefit plan, if the dependent loses eligibility for
34 coverage because of the death, divorce, or retirement
35 of the employee, as required by Section 3B, Article
36 3.51-6, of this code.

37 [Sections 1501.160-1501.200 reserved for expansion]

38 SUBCHAPTER E. UNDERWRITING AND RATING OF SMALL EMPLOYER HEALTH
39 BENEFIT PLANS

40 Revised Law

41 Sec. 1501.201. DEFINITIONS. In this subchapter:

42 (1) "Base premium rate" means, for each class of
43 business and for a specific rating period, the lowest premium rate

1 that is charged or that could be charged under a rating system for
2 that class of business by a small employer health benefit plan
3 issuer to small employers with similar case characteristics for
4 small employer health benefit plans that provide the same or
5 similar coverage.

6 (2) "Case characteristics" means, with respect to a
7 small employer, the geographic area in which the employer's
8 employees reside, the age and gender of the individual employees
9 and their dependents, the number of employees and dependents, the
10 appropriate industry classification as determined by the small
11 employer health benefit plan issuer, and other objective criteria
12 established by the issuer that are considered by the issuer in
13 setting premium rates for the employer. The term does not include:

14 (A) health status related factors;

15 (B) duration of coverage since the date of
16 issuance of a health benefit plan; or

17 (C) whether a covered individual is or may become
18 pregnant.

19 (3) "Class of business" means all small employers or a
20 separate grouping of small employers established under this
21 subchapter.

22 (4) "Index rate" means, for each class of business and
23 for a specific rating period for small employers with similar case
24 characteristics, the arithmetic average of the applicable base
25 premium rate and corresponding highest premium rate.

26 (5) "New business premium rate" means, for each class
27 of business and for a specific rating period, the lowest premium
28 rate that is charged or offered or that could be charged or offered
29 by a small employer health benefit plan issuer to small employers
30 with similar case characteristics for newly issued small employer
31 health benefit plans that provide the same or similar coverage.

32 (6) "Rating period" means a calendar period during
33 which premium rates established by a small employer health benefit
34 plan issuer are assumed to be in effect. (V.T.I.C. Art. 26.02,

1 Subdivs. (3), (5), (6), (14), (19), (26).)

2 Source Law

3 Art. 26.02. In this chapter:

4 (3) "Base premium rate" means, for each
5 class of business and for a specific rating period, the
6 lowest premium rate that is charged or that could be
7 charged under a rating system for that class of
8 business by the small employer carrier to small
9 employers with similar case characteristics for small
10 employer health benefit plans with the same or similar
11 coverage.

12 (5) "Case characteristics" means, with
13 respect to a small employer, the geographic area in
14 which that employer's employees reside, the age and
15 gender of the individual employees and their
16 dependents, the appropriate industry classification
17 as determined by the small employer carrier, the
18 number of employees and dependents, and other
19 objective criteria as established by the small
20 employer carrier that are considered by the small
21 employer carrier in setting premium rates for that
22 small employer. The term does not include health
23 status related factors, duration of coverage since the
24 date of issuance of a health benefit plan, or whether a
25 covered person is or may become pregnant.

26 (6) "Class of business" means all small
27 employers or a separate grouping of small employers
28 established under this chapter.

29 (14) "Index rate" means, for each class of
30 business as to a rating period for small employers with
31 similar case characteristics, the arithmetic average
32 of the applicable base premium rate and corresponding
33 highest premium rate.

34 (19) "New business premium rate" means,
35 for each class of business as to a rating period, the
36 lowest premium rate that is charged or offered or that
37 could be charged or offered by the small employer
38 carrier to small employers with similar case
39 characteristics for newly issued small employer health
40 benefit plans that provide the same or similar
41 coverage.

42 (26) "Rating period" means a calendar
43 period for which premium rates established by a small
44 employer carrier are assumed to be in effect.

45 Revised Law

46 Sec. 1501.202. ESTABLISHMENT OF CLASSES OF BUSINESS. (a)
47 Except as otherwise provided by this subchapter, a small employer
48 health benefit plan issuer may not establish a separate class or
49 classes of business for small employers.

50 (b) A small employer health benefit plan issuer may
51 establish a separate class of business only to reflect substantial
52 differences in expected claims experience or administrative costs

1 related to the following reasons:

2 (1) the issuer uses more than one type of system to
3 market and sell small employer health benefit plans to small
4 employers;

5 (2) the issuer has acquired a class of business from
6 another small employer health benefit plan issuer; or

7 (3) the issuer provides coverage to one or more
8 employer-based association groups.

9 (c) Except as provided by Subsection (e), a small employer
10 health benefit plan issuer may not establish more than nine
11 separate classes of business under this section.

12 (d) The commissioner may adopt rules to provide for a
13 transition period to permit a small employer health benefit plan
14 issuer to comply with Subsection (c) after acquiring an additional
15 class of business from another small employer health benefit plan
16 issuer.

17 (e) On application to the commissioner, the commissioner
18 may approve the establishment of additional classes of business if
19 the commissioner finds that the establishment of additional classes
20 would enhance the efficiency and fairness of the health coverage
21 market for small employers. (V.T.I.C. Art. 26.21, Subsec. (g);
22 Art. 26.31, Subsecs. (a), (b), (c), (d).)

23 Source Law

24 [Art. 26.21]

25 (g) Except as otherwise provided by this
26 chapter, a small employer carrier may not establish a
27 separate class or classes of business for small
28 employers.

29 Art. 26.31. (a) A small employer carrier may
30 establish a separate class of business only to reflect
31 substantial differences in expected claim experience
32 or administrative costs related to the following
33 reasons:

34 (1) the small employer carrier uses more
35 than one type of system for the marketing and sale of
36 small employer health benefit plans to small
37 employers;

38 (2) the small employer carrier has
39 acquired a class of business from another health
40 carrier; or

41 (3) the small employer carrier provides
42 coverage to one or more employer-based association
43 groups.

1 (b) A small employer carrier may establish up to
2 nine separate classes of business under this article.

3 (c) The commissioner may establish regulations
4 to provide for a period of transition in order for a
5 small employer carrier to come into compliance with
6 Subsection (b) of this article in the instance of
7 acquisition of an additional class of business from
8 another small employer carrier.

9 (d) The commissioner may approve the
10 establishment of additional classes of business on
11 application to the commissioner and a finding by the
12 commissioner that the establishment of additional
13 classes would enhance the efficiency and fairness of
14 the insurance market for small employers.

15 Revisor's Note

16 Subsection (c), V.T.I.C. Article 26.31, refers to
17 "regulations." The revised law substitutes "rules" for
18 "regulations" because under Section 311.005(5),
19 Government Code (Code Construction Act), a rule is
20 defined to include a regulation. That definition
21 applies to the revised law.

22 Revised Law

23 Sec. 1501.203. ESTABLISHMENT OF CLASSES OF BUSINESS ON
24 CERTAIN BASES PROHIBITED. (a) A small employer health benefit
25 plan issuer may not establish a separate class of business based on:

26 (1) participation requirements; or

27 (2) whether the coverage provided to a small employer
28 group is provided on a guaranteed issue basis or is subject to
29 underwriting or proof of insurability.

30 (b) A small employer health benefit plan issuer may not
31 directly or indirectly use as a criterion for establishing a
32 separate class of business:

33 (1) the number of employees and dependents of a small
34 employer; or

35 (2) except as provided by Section 1501.202(b)(3), the
36 trade or occupation of the employees of a small employer or the
37 industry or type of business of the small employer. (V.T.I.C. Art.
38 26.31, Subsecs. (e), (f), (g).)

39 Source Law

40 (e) A small employer carrier may not establish a
41 separate class of business based on participation
42 requirements.

1 (f) A small employer carrier may not establish a
2 separate class of business based on whether the
3 coverage provided to a small employer group is
4 provided on a guaranteed issue basis or is subject to
5 underwriting or proof of insurability.

6 (g) A small employer carrier may not directly or
7 indirectly use as a criterion for establishing a
8 separate class of business:

9 (1) the number of employees and dependents
10 of a small employer; or

11 (2) except as provided in Subsection
12 (a)(3) of this article, the trade or occupation of the
13 employees of a small employer or the industry or type
14 of business of the small employer.

15 Revised Law

16 Sec. 1501.204. INDEX RATES. Under a small employer health
17 benefit plan:

18 (1) the index rate for a class of business may not
19 exceed the index rate for any other class of business by more than
20 20 percent; and

21 (2) premium rates charged during a rating period to
22 small employers in a class of business with similar case
23 characteristics for the same or similar coverage, or premium rates
24 that could be charged to those employers under the rating system for
25 that class of business, may not vary from the index rate by more
26 than 25 percent. (V.T.I.C. Art. 26.32, Subsecs. (a), (b), (c).)

27 Source Law

28 Art. 26.32. (a) The premium rates for a small
29 employer health benefit plan are subject to this
30 article.

31 (b) The index rate for a rating period for any
32 class of business may not exceed the index rate for any
33 other class of business by more than 20 percent.

34 (c) For a class of business, the premium rates
35 charged during a rating period to small employers with
36 similar case characteristics for the same or similar
37 coverage, or the rates that could be charged to those
38 employers under the rating system for that class of
39 business, may not vary from the index rate by more than
40 25 percent.

41 Revisor's Note

42 Subsection (b), V.T.I.C. Article 26.32, refers to
43 the index rate "for a rating period." The revised law
44 omits the quoted language as unnecessary because the
45 definition of "index rate" under Subdivision (14),
46 V.T.I.C. Article 26.02, revised as Section
47 1501.201(4), provides that an index rate is for a

1 particular rating period.

2 Revised Law

3 Sec. 1501.205. PREMIUM RATES: ESTABLISHMENT. (a) In this
4 section:

5 (1) "Risk characteristic" means:

6 (A) a health status related factor;

7 (B) the duration of coverage; or

8 (C) any characteristic similar to a
9 characteristic described by Paragraph (A) or (B) that is related to
10 the health status or experience of a small employer group or of any
11 member of a small employer group.

12 (2) "Risk load" means the percentage above the
13 applicable base premium rate a small employer health benefit plan
14 issuer charges to a small employer to reflect the risk
15 characteristics associated with that particular small employer
16 group.

17 (b) Small employer health benefit plan issuers shall
18 develop premium rates for each small employer group in a two-step
19 process. In the first step, the small employer health benefit plan
20 issuer shall develop a base premium rate for each small employer
21 group without regard to any risk characteristic of the group. In
22 the second step, the small employer health benefit plan issuer may
23 adjust the resulting base premium rate by the risk load of the
24 group, subject to this subchapter, to reflect the risk
25 characteristics of the group.

26 (c) The risk load assessed to a particular group shall
27 reflect the risk characteristics of the particular group.
28 (V.T.I.C. Art. 26.02, Subdivs. (28), (29), as amended Acts 77th
29 Leg., R.S., Ch. 823; Art. 26.32, Subsecs. (d), (e).)

30 Source Law

31 Art. 26.02. [as amended Acts 77th Leg., R.S., Ch.
32 823] In this chapter:

33 (28) "Risk characteristic" means:

34 (A) a health status related factor;

35 (B) the duration of coverage; or

36 (C) any characteristic similar to a

1 characteristic described by Paragraph (A) or (B) of
2 this subdivision that is related to the health status
3 or experience of a small employer group or of any
4 member of a small employer group.

5 (29) "Risk load" means the percentage
6 above the applicable base premium rate a small
7 employer carrier charges to a small employer to
8 reflect the risk characteristics associated with that
9 particular small employer group.

10 [Art. 26.32]

11 (d) Small employer carriers shall develop
12 premium rates for each small employer group in a
13 two-step process. In the first step, the small
14 employer carrier shall develop a base premium rate for
15 each small employer group without regard to any risk
16 characteristic of the group. In the second step, the
17 small employer carrier may adjust the resulting base
18 premium rate by the risk load of the group, subject to
19 the provisions of this subchapter, to reflect the risk
20 characteristics of the group.

21 (e) The risk load assessed to a particular group
22 shall reflect the risk characteristics of the
23 particular group.

24 Revised Law

25 Sec. 1501.206. PREMIUM RATES: ADJUSTMENTS. (a) The
26 percentage increase in the premium rate charged to a small employer
27 for a new rating period may not exceed the sum of:

28 (1) the percentage change in the new business premium
29 rate, measured from the first day of the preceding rating period to
30 the first day of the new rating period;

31 (2) any adjustment, not to exceed 15 percent annually
32 and adjusted pro rata for a rating period of less than one year, due
33 to the claims experience, health status, or duration of coverage of
34 the employees or dependents of employees of the small employer, as
35 determined under the small employer health benefit plan issuer's
36 rate manual for the class of business; and

37 (3) any adjustment due to change in coverage or change
38 in the case characteristics of the small employer, as determined
39 under the issuer's rate manual for the class of business.

40 (b) An adjustment in the premium rate for claims experience,
41 health status, or duration of coverage:

42 (1) may not be charged to individual employees or
43 dependents; and

44 (2) must be applied uniformly to the rates charged for
45 all employees and dependents of employees of the small employer.

1 (V.T.I.C. Art. 26.33, Subsecs. (a), (b).)

2 Source Law

3 Art. 26.33. (a) The percentage increase in the
4 premium rate charged to a small employer for a new
5 rating period may not exceed the sum of:

6 (1) the percentage change in the new
7 business premium rate measured from the first day of
8 the prior rating period to the first day of the new
9 rating period;

10 (2) any adjustment, not to exceed 15
11 percent annually and adjusted pro rata for rating
12 periods of less than one year, due to the claim
13 experience, health status, or duration of coverage of
14 the employees or dependents of the small employer as
15 determined from the small employer carrier's rate
16 manual for the class of business; and

17 (3) any adjustment due to change in
18 coverage or change in the case characteristics of the
19 small employer as determined from the small employer
20 carrier's rate manual for the class of business.

21 (b) Adjustments in premium rates for claim
22 experience, health status, or duration of coverage may
23 not be charged to individual employees or dependents.
24 Such an adjustment must be applied uniformly to the
25 rates charged for all employees and dependents of
26 employees of the small employer.

27 Revised Law

28 Sec. 1501.207. PREMIUM RATE ADJUSTMENT IN CLOSED PLAN. For
29 a closed health benefit plan under which a small employer health
30 benefit plan issuer is no longer enrolling new small employers, the
31 issuer shall use the percentage change in the base premium rate to
32 adjust premium rates under Section 1501.206(a)(1). The portion of
33 change in premium rates computed under that subdivision may not
34 exceed, on a percentage basis, the change in the new business
35 premium rate for the most similar health benefit plan under which
36 the issuer is enrolling new small employers. (V.T.I.C. Art.
37 26.35.)

38 Source Law

39 Art. 26.35. In the case of a health benefit plan
40 into which a small employer carrier is no longer
41 enrolling new small employers, the small employer
42 carrier shall use the percentage change in the base
43 premium rate to adjust rates under Articles
44 26.33(a)(1) and 26.34(1) of this code. The portion of
45 change in rates computed under those subdivisions may
46 not exceed, on a percentage basis, the change in the
47 new business premium rate for the most similar health
48 benefit plan into which the small employer carrier is
49 actively enrolling new small employers.

1 Revisor's Note

2 V.T.I.C. Article 26.35 refers to "Articles
3 26.33(a)(1) and 26.34(1) of this code." The revised
4 law omits the reference to Article 26.34(1) because
5 Article 26.34 is omitted from this revision. See the
6 revisor's note at the end of this subchapter.

7 Revised Law

8 Sec. 1501.208. PREMIUM RATES: INDUSTRY CLASSIFICATION. A
9 small employer health benefit plan issuer may use the industry
10 classification to which a small employer belongs as a case
11 characteristic in establishing the premium rate, but the highest
12 rate factor associated with any industry classification may not
13 exceed by more than 15 percent the lowest rate factor associated
14 with any industry classification. (V.T.I.C. Art. 26.33, Subsec.
15 (c).)

16 Source Law

17 (c) A health carrier may use the industry
18 classification to which a small employer belongs as a
19 case characteristic in establishing premium rates, but
20 the highest rate factor associated with any industry
21 classification may not exceed the lowest rate factor
22 associated with any industry classification by more
23 than 15 percent.

24 Revised Law

25 Sec. 1501.209. PREMIUM RATES: NUMBER OF EMPLOYEES. A small
26 employer health benefit plan issuer may use the number of employees
27 and dependents of a small employer as a case characteristic in
28 establishing premium rates for the group. The highest rate factor
29 associated with a classification based on the number of employees
30 and dependents of a small employer may not exceed by more than 20
31 percent the lowest rate factor associated with a classification
32 based on the number of employees and dependents of a small employer.
33 (V.T.I.C. Art. 26.33, Subsec. (d).)

34 Source Law

35 (d) A small employer carrier may use the number
36 of employees and dependents of a small employer as a
37 case characteristic in establishing premium rates for
38 the group. The highest rate factor associated with a
39 classification based on the number of employees and

1 dependents of a small employer may not exceed by more
2 than 20 percent the lowest rate factor associated with
3 a classification based on the number of employees and
4 dependents of a small employer.

5 Revised Law

6 Sec. 1501.210. PREMIUM RATES: NONDISCRIMINATION. (a) A
7 small employer health benefit plan issuer shall apply rating
8 factors, including case characteristics, consistently with respect
9 to all small employers in a class of business. Rating factors must
10 produce premium rates for identical groups that:

11 (1) differ only by the amounts attributable to health
12 benefit plan design; and

13 (2) do not reflect differences because of the nature
14 of the groups assumed to select particular health benefit plans.

15 (b) A small employer health benefit plan issuer shall treat
16 each health benefit plan issued or renewed in the same calendar
17 month as having the same rating period.

18 (c) Without the prior approval of the commissioner, a small
19 employer health benefit plan issuer may not use case
20 characteristics other than:

21 (1) the geographic area in which the small employer's
22 employees reside;

23 (2) the age and gender of the individual employees and
24 their dependents;

25 (3) the number of employees and dependents; and

26 (4) the appropriate industry classification.

27 (d) Premium rates for a small employer health benefit plan
28 must comply with the requirements of this chapter, notwithstanding
29 any assessment paid or payable by a small employer health benefit
30 plan issuer.

31 (e) A small employer health benefit plan issuer may not
32 transfer a small employer involuntarily into or out of a class of
33 business. The issuer may not offer to transfer a small employer
34 into or out of a class of business unless the offer is made to
35 transfer all other small employers in the employer's class of
36 business without regard to case characteristics, claims

1 experience, health status, or duration of coverage since the
2 issuance of the health benefit plan. (V.T.I.C. Art. 26.36,
3 Subsecs. (a), (b), (c), (d), (f).)

4 Source Law

5 Art. 26.36. (a) A small employer carrier shall
6 apply rating factors, including case characteristics,
7 consistently with respect to all small employers in a
8 class of business. Rating factors shall produce
9 premiums for identical groups that differ only by the
10 amounts attributable to plan design and that do not
11 reflect differences due to the nature of the groups
12 assumed to select particular health benefit plans.

13 (b) A small employer carrier shall treat each
14 health benefit plan issued or renewed in the same
15 calendar month as having the same rating period.

16 (c) A small employer carrier may not use case
17 characteristics without the prior approval of the
18 commissioner other than the geographic area in which
19 the small employer's employees reside, the age and
20 gender of the individual employees and their
21 dependents, the appropriate industry classification,
22 and the number of employees and dependents.

23 (d) Premium rates for a small employer health
24 benefit plan must comply with the requirements of this
25 chapter, notwithstanding any assessments paid or
26 payable by small employer carriers.

27 (f) A small employer carrier may not transfer a
28 small employer involuntarily into or out of a class of
29 business. A small employer carrier may not offer to
30 transfer a small employer into or out of a class of
31 business unless the offer is made to transfer all small
32 employers in that class of business without regard to
33 case characteristics, claim experience, health
34 status, or duration of coverage since the issuance of
35 the health benefit plan.

36 Revised Law

37 Sec. 1501.211. RULES CONCERNING PREMIUM RATES. Rules
38 adopted under Section 1501.010 may ensure that:

39 (1) rating practices used by small employer health
40 benefit plan issuers are consistent with the purposes of this
41 chapter; and

42 (2) differences in premium rates charged for each
43 small employer health benefit plan are reasonable and reflect
44 objective differences in plan design. (V.T.I.C. Art. 26.36,
45 Subsec. (e).)

46 Source Law

47 (e) The board may adopt rules to implement this
48 article and to ensure that rating practices used by
49 small employer carriers are consistent with the
50 purposes of this chapter, including rules that ensure

1 that differences in rates charged for each small
2 employer health benefit plan are reasonable and
3 reflect objective differences in plan design.

4 Revisor's Note

5 (1) Subsection (e), V.T.I.C. Article 26.36,
6 refers to the "board," meaning the State Board of
7 Insurance. Chapter 685, Acts of the 73rd Legislature,
8 Regular Session, 1993, abolished the State Board of
9 Insurance and transferred its functions to the
10 commissioner of insurance and the Texas Department of
11 Insurance. Throughout this chapter, references to the
12 State Board of Insurance have been changed
13 appropriately.

14 (2) Subsection (e), V.T.I.C. Article 26.36,
15 provides that the State Board of Insurance "may adopt
16 rules to implement this article." V.T.I.C. Article
17 26.04, revised as Section 1501.010, requires the
18 commissioner of insurance to adopt rules necessary to
19 implement V.T.I.C. Chapter 26. Accordingly, the
20 revised law omits the portion of Subsection (e),
21 Article 26.36, authorizing the adoption of rules and
22 substitutes a cross-reference to Section 1501.010.

23 Revised Law

24 Sec. 1501.212. RESTRICTED PROVIDER NETWORK. (a) A small
25 employer health benefit plan may use a restricted provider network
26 to provide benefits under the plan.

27 (b) A small employer health benefit plan that uses a
28 restricted provider network does not provide similar coverage to a
29 plan that does not use a restricted provider network if the use of
30 the network results in reduced premium rates charged to the small
31 employer or substantial differences in claim costs. (V.T.I.C. Art.
32 26.37.)

33 Source Law

34 Art. 26.37. For purposes of this subchapter, a
35 small employer health benefit plan may use a
36 restricted provider network to provide the benefits
37 under the plan. A plan that uses a restricted provider

1 network does not provide similar coverage to a small
2 employer health benefit plan that does not use a
3 restricted provider network, if the use of the network
4 results in reduced premiums to the small employer or
5 substantial differences in claim costs.

6 Revised Law

7 Sec. 1501.213. PREMIUM RATES: HEALTH MAINTENANCE
8 ORGANIZATION HEALTH BENEFIT PLAN. (a) The premium rates for a
9 state-approved health benefit plan offered by a health maintenance
10 organization under Section 1501.255 must be established in
11 accordance with formulas or schedules of charges filed with the
12 department.

13 (b) A health maintenance organization that participates in
14 a purchasing cooperative that provides employees of small employers
15 a choice of health benefit plans may use rating methods in
16 accordance with this subchapter that are used by other small
17 employer health benefit plan issuers participating in the same
18 cooperative, including rating by age and gender, if the health
19 maintenance organization has established:

20 (1) a separate class of business, as provided by
21 Section 1501.202; and

22 (2) a separate line of business, as provided under
23 Section 1501.255(b) and Title XIII, Public Health Service Act (42
24 U.S.C. Section 300e et seq.). (V.T.I.C. Art. 26.38.)

25 Source Law

26 Art. 26.38. (a) The premium rates for a
27 state-approved health benefit plan offered by a health
28 maintenance organization under Article 26.48 of this
29 code must be established in accordance with formulas
30 or schedules of charges filed with the department.

31 (b) A health maintenance organization that
32 participates in a purchasing cooperative that provides
33 employees of small employers a choice of benefit
34 plans, that has established a separate class of
35 business as provided by Article 26.31 of this code, and
36 that has established a separate line of business as
37 provided under Article 26.48(a) of this code and Title
38 XIII, Public Health Service Act (42 U.S.C. Section
39 300e et seq.) may use rating methods in accordance with
40 this subchapter that are used by other small employer
41 carriers participating in the same cooperative,
42 including rating by age and gender.

43 Revised Law

44 Sec. 1501.214. ENFORCEMENT. If the commissioner determines

1 that a small employer health benefit plan issuer subject to this
2 chapter exceeds the applicable premium rate established under this
3 subchapter, the commissioner may order restitution and assess
4 penalties as provided by Chapter 82. (V.T.I.C. Art. 26.39.)

5 Source Law

6 Art. 26.39. If the commissioner finds that a
7 small employer carrier subject to this chapter exceeds
8 the applicable rate established under this subchapter,
9 the commissioner may order restitution and assess
10 penalties as provided by Section 7, Article 1.10, of
11 this code.

12 Revised Law

13 Sec. 1501.215. REPORTING REQUIREMENTS. (a) Annually, each
14 small employer health benefit plan issuer that offers a small
15 employer health benefit plan shall file with the commissioner an
16 actuarial certification stating that the issuer's underwriting and
17 rating methods:

18 (1) comply with accepted actuarial practices;

19 (2) are uniformly applied to each small employer
20 health benefit plan covering a small employer; and

21 (3) comply with this subchapter.

22 (b) Each small employer health benefit plan issuer shall
23 maintain at its principal place of business a complete and detailed
24 description of its rating practices and renewal underwriting
25 practices, including information and documentation that
26 demonstrate that its rating methods and practices are based on
27 commonly accepted actuarial assumptions and are in accordance with
28 sound actuarial principles.

29 (c) A small employer health benefit plan issuer shall make
30 the information and documentation described in Subsection (b)
31 available to the commissioner on request. Unless the information
32 or documentation relates to a violation of this chapter, the
33 information or documentation is considered proprietary and trade
34 secret information and is not subject to disclosure by the
35 commissioner to a person outside the department except as agreed to
36 by the issuer or as ordered by a court. (V.T.I.C. Art. 26.41.)

1 Source Law

2 Art. 26.41. (a) Compliance with the
3 underwriting and rating requirements of this chapter
4 shall be demonstrated through actuarial
5 certification. Small employer carriers offering a
6 small employer health benefit plan shall file annually
7 with the commissioner an actuarial certification
8 stating that the underwriting and rating methods of
9 the small employer carrier:

10 (1) comply with accepted actuarial
11 practices;

12 (2) are uniformly applied to each small
13 employer health benefit plan covering a small
14 employer; and

15 (3) comply with the provisions of this
16 chapter.

17 (b) Each small employer carrier shall maintain
18 at its principal place of business a complete and
19 detailed description of its rating practices and
20 renewal underwriting practices, including information
21 and documentation that demonstrate that its rating
22 methods and practices are based on commonly accepted
23 actuarial assumptions and are in accordance with sound
24 actuarial principles.

25 (c) A small employer carrier shall make the
26 information and documentation described in Subsection
27 (b) of this article available to the commissioner on
28 request. Except in cases of violations of this
29 chapter, the information shall be considered
30 proprietary and trade secret information and shall not
31 be subject to disclosure by the commissioner to
32 persons outside the department except as agreed to by
33 the small employer carrier or as ordered by a court of
34 competent jurisdiction.

35 Revisor's Note

36 Subsection (c), V.T.I.C. Article 26.41, refers to
37 a court "of competent jurisdiction." The revised law
38 omits the quoted language as unnecessary because the
39 general laws of civil jurisdiction determine which
40 courts have jurisdiction over the matter. For
41 example, see Sections 24.007-24.011, Government Code,
42 for the general jurisdiction of district courts.

43 Revisor's Note
44 (End of Subchapter)

45 V.T.I.C. Article 26.34 permits premium rates for
46 certain small employer health benefit plans to "exceed
47 the ranges set forth in Articles 26.32 and 26.33 of
48 this code [revised as Sections 1501.204, 1501.206, and
49 1501.208] until September 1, 1995." The revised law
50 omits this provision as obsolete because premium rates
51 for all small employer health benefit plans must now

1 comply with those articles. The omitted law reads:

2 Art. 26.34. For a health benefit plan
3 delivered or issued for delivery before
4 September 1, 1993, a premium rate for a
5 rating period may exceed the ranges set
6 forth in Articles 26.32 and 26.33 of this
7 code until September 1, 1995. The
8 percentage increase in the premium rate
9 charged to a small employer under this
10 article for a new rating period may not
11 exceed the sum of:

12 (1) the percentage change in
13 the new business premium rate measured from
14 the first day of the prior rating period to
15 the first day of the new rating period; and

16 (2) any adjustment due to
17 change in coverage or change in the case
18 characteristics of the small employer as
19 determined from the small employer
20 carrier's rate manual for the class of
21 business.

22 [Sections 1501.216-1501.250 reserved for expansion]

23 SUBCHAPTER F. COVERAGE UNDER SMALL EMPLOYER HEALTH BENEFIT PLANS

24 Revised Law

25 Sec. 1501.251. EXCEPTION FROM CERTAIN MANDATED BENEFIT
26 REQUIREMENTS. Except as expressly provided by this chapter, a
27 small employer health benefit plan is not subject to a law that
28 requires coverage or the offer of coverage of a health care service
29 or benefit. (V.T.I.C. Art. 26.06, Subsec. (d).)

30 Source Law

31 (d) Except as expressly provided in this
32 chapter, a small employer health benefit plan is not
33 subject to a law that requires coverage or the offer of
34 coverage of a health care service or benefit.

35 Revised Law

36 Sec. 1501.252. HEALTH BENEFIT PLANS. (a) A small
37 employer health benefit plan issuer shall offer the following two
38 health benefit plans as adopted by the commissioner:

39 (1) the catastrophic care health benefit plan; and

40 (2) the basic coverage health benefit plan.

41 (b) A small employer health benefit plan issuer may offer to
42 a small employer additional benefit riders to either of the health
43 benefit plans required by Subsection (a).

44 (c) Subject to this chapter, a small employer health benefit
45 plan issuer may also offer to a small employer any other health

1 benefit plan authorized under this code. Section 1501.251 does not
2 apply to a health benefit plan offered to a small employer under
3 this subsection. (V.T.I.C. Art. 26.42.)

4 Source Law

5 Art. 26.42. (a) A small employer carrier shall
6 offer the following two health benefit plans as
7 adopted by the commissioner:

8 (1) the catastrophic care benefit plan;
9 and

10 (2) the basic coverage benefit plan.

11 (b) A small employer carrier may offer to a
12 small employer additional benefit riders to either of
13 the benefit plans.

14 (c) Subject to the provisions of this chapter, a
15 small employer carrier may also offer to small
16 employers any other health benefit plan authorized
17 under this code. Article 26.06(c) does not apply to a
18 health benefit plan offered to a small employer under
19 this subsection.

20 Revisor's Note

21 Subsection (c), V.T.I.C. Article 26.42, provides
22 that "Article 26.06(c)" of this code does not apply to
23 certain health benefit plans offered by a small
24 employer carrier. As originally enacted in 1993,
25 Subsection (c), Article 26.06, provided that "[e]xcept
26 as expressly provided in this chapter, a small
27 employer health benefit plan is not subject to a law
28 that requires coverage or the offer of coverage of a
29 health care service or benefit." Article 26.06 was
30 amended by Section 1.05, Chapter 955, Acts of the 75th
31 Legislature, Regular Session, 1997. The 1997
32 amendment added a new Subsection (b) to Article 26.06
33 and relettered existing Subsections (b) and (c) as (c)
34 and (d), respectively. However, the 1997 amendment
35 failed to correct the cross-reference in Article
36 26.42. The revised law is drafted to correct that
37 cross-reference.

38 Revised Law

39 Sec. 1501.253. COVERAGE REQUIREMENTS. (a) The
40 commissioner by rule shall establish coverage requirements for the
41 catastrophic care health benefit plan and the basic coverage health

1 benefit plan.

2 (b) Coverage under the catastrophic care health benefit
3 plan must be designed to provide necessary coverage in the event of
4 catastrophic illness or injury. The commissioner shall establish
5 deductibles and coinsurance requirements at levels that permit
6 options for a covered individual to obtain affordable catastrophic
7 coverage.

8 (c) Coverage under the basic coverage health benefit plan
9 must be designed to provide basic hospital, medical, and surgical
10 coverage. Benefits under the plan are limited to basic care
11 requirements for illness and injury.

12 (d) The benefits provisions of the catastrophic care and
13 basic coverage health benefit plan policies must include:

- 14 (1) all required or applicable definitions;
15 (2) a description of covered services required under
16 the plan;
17 (3) a list of any exclusions or limitations to
18 coverage; and
19 (4) the deductible and coinsurance options that are
20 required or permitted under the plan. (V.T.I.C. Art. 26.44A,
21 Subsecs. (a) (part), (b), (c), (d).)

22 Source Law

23 Art. 26.44A. (a) The commissioner by rule shall
24 establish the coverage requirements for the
25 catastrophic care benefit plan and the basic coverage
26 benefit plan. . . .

27 (b) Coverage under the catastrophic care
28 benefit plan must be designed to provide necessary
29 coverage in the event of catastrophic illness or
30 injury. The commissioner shall establish deductibles
31 and coinsurance requirements at levels that permit
32 options for the insured to obtain affordable
33 catastrophic coverage.

34 (c) The commissioner by rule shall establish
35 coverage requirements for the basic coverage benefit
36 plan. Coverage under the basic coverage benefit plan
37 must be designed to provide basic hospital, medical,
38 and surgical coverages. Benefits under the plan are
39 limited to basic care requirements for illness and
40 injury.

41 (d) The benefits provisions of the benefit plan
42 policies must include the following:

- 43 (1) all required or applicable
44 definitions;
45 (2) a list of any exclusions or

1 limitations to coverage;
2 (3) a description of covered services
3 required under the plan; and
4 (4) the deductible and coinsurance options
5 that are required or permitted under the plan.

6 Revised Law

7 Sec. 1501.254. ALCOHOL AND SUBSTANCE ABUSE BENEFITS. (a)
8 This section applies only if the basic coverage health benefit plan
9 developed by the commissioner under Section 1501.253 includes
10 coverage for alcohol and substance abuse benefits.

11 (b) A small employer health benefit plan issuer may offer
12 and the employees of a small employer group may accept a basic
13 coverage health benefit plan without coverage for alcohol and
14 substance abuse benefits if:

15 (1) at least 50 percent of the employees in writing:

16 (A) waive the benefits; and

17 (B) indicate that they have undergone alcoholism
18 or substance abuse treatment or counseling within the preceding
19 three years; and

20 (2) the exclusion of those benefits applies only to
21 those employees. (V.T.I.C. Art. 26.44B.)

22 Source Law

23 Art. 26.44B. If the small employer basic
24 coverage benefit plan developed by the commissioner
25 includes coverage for alcohol and substance abuse
26 benefits, the employees of a small employer group may
27 accept and small employer carriers may offer the basic
28 coverage benefit plan without providing coverage for
29 alcohol and substance abuse benefits if:

30 (1) at least 50 percent of the employees
31 waive in writing the benefits and indicate in writing
32 that they have undergone alcoholism or substance abuse
33 treatment or counseling within the last three years;
34 and

35 (2) the exclusion from coverage of alcohol
36 and substance abuse applies to only those employees.

37 Revised Law

38 Sec. 1501.255. HEALTH MAINTENANCE ORGANIZATION PLANS. (a)
39 In this section, "point-of-service contract" means a health benefit
40 plan offered through a health maintenance organization that:

41 (1) includes corresponding indemnity benefits in
42 addition to benefits relating to out-of-area or emergency services
43 provided through insurers or group hospital service corporations;

1 and

2 (2) permits the covered individual to obtain coverage
3 under either the health maintenance organization conventional plan
4 or the indemnity plan as determined in accordance with the terms of
5 the contract.

6 (b) A health maintenance organization may offer:

7 (1) a state-approved health benefit plan that complies
8 with this chapter, Chapters 843, 1271, 1272, and 1367, Subchapter
9 A, Chapter 1452, Title XIII, Public Health Service Act (42 U.S.C.
10 Section 300e et seq.), and its subsequent amendments, and rules
11 adopted under those laws;

12 (2) a health benefit plan developed by the
13 commissioner under Section 1501.253 and additional benefit riders
14 to the plan; or

15 (3) a point-of-service contract in connection with an
16 insurer that includes optional coverage for out-of-area services,
17 emergency care, or out-of-network care.

18 (c) A point-of-service contract offered under Subsection
19 (b)(3) is subject to this chapter unless specifically exempted.
20 The insurer with which the health maintenance organization offers a
21 point-of-service contract is not required to otherwise make
22 available the health benefit plans adopted under this subchapter if
23 the insurer's small employer products are limited to the
24 point-of-service contract. (V.T.I.C. Art. 26.02, Subdiv. (23);
25 Art. 26.48.)

26 Source Law

27 Art. 26.02. In this chapter:

28 (23) "Point-of-service contract" means a
29 benefit plan offered through a health maintenance
30 organization that:

31 (A) includes corresponding indemnity
32 benefits in addition to benefits relating to
33 out-of-area or emergency services provided through
34 insurers or group hospital service corporations; and

35 (B) permits the insured to obtain
36 coverage under either the health maintenance
37 organization conventional plan or the indemnity plan
38 as determined in accordance with the terms of the
39 contract.

1 Revised Law

2 Sec. 1501.256. COORDINATION WITH FEDERAL LAW. (a) To the
3 extent required to comply with federal law applicable to a small
4 employer health benefit plan described by this subchapter, the
5 commissioner by rule may:

6 (1) modify the plan; or

7 (2) adopt a substitute for the plan.

8 (b) The commissioner shall use the Texas Health Benefits
9 Purchasing Cooperative in implementing this section. (V.T.I.C.
10 Art. 26.50.)

11 Source Law

12 Art. 26.50. The board by rule may modify a small
13 employer benefit plan described by this subchapter or
14 adopt a substitute for that plan to the extent required
15 to comply with federal law applicable to the plan. The
16 board shall use the Texas Health Benefits Purchasing
17 Cooperative in the implementation of this article.

18 Revised Law

19 Sec. 1501.257. COST CONTAINMENT. (a) A small employer
20 health benefit plan issuer may use cost containment and managed
21 care features in a small employer health benefit plan, including:

22 (1) utilization review of health care services,
23 including review of the medical necessity of hospital and physician
24 services;

25 (2) case management, including discharge planning and
26 review of stays in hospitals or other health care facilities;

27 (3) selective contracting with hospitals, physicians,
28 and other health care providers;

29 (4) reasonable benefit differentials applicable to
30 health care providers that participate or do not participate in
31 restricted network arrangements;

32 (5) precertification or preauthorization for certain
33 covered services; and

34 (6) coordination of benefits.

35 (b) A provision of a small employer health benefit plan that
36 provides for coordination of benefits must comply with this chapter

1 and guidelines established by the commissioner.

2 (c) Utilization review performed for any cost containment,
3 case management, or managed care arrangement must comply with
4 Article 21.58A. (V.T.I.C. Art. 26.08.)

5 Source Law

6 Art. 26.08. (a) A small employer carrier may
7 use cost containment and managed care features in a
8 small employer health benefit plan, including:

9 (1) utilization review of health care
10 services, including review of the medical necessity of
11 hospital and physician services;

12 (2) case management, including discharge
13 planning and review of stays in hospitals or other
14 health care facilities;

15 (3) selective contracting with hospitals,
16 physicians, and other health care providers;

17 (4) reasonable benefit differentials
18 applicable to health care providers that participate
19 or do not participate in restricted network
20 arrangements;

21 (5) precertification or preauthorization
22 for certain covered services; and

23 (6) coordination of benefits.

24 (b) A provision of a small employer health
25 benefit plan that provides for coordination of
26 benefits must comply with this chapter and guidelines
27 established by the commissioner.

28 (c) Utilization review performed for any cost
29 containment, case management, or managed care
30 arrangement must comply with Article 21.58A of this
31 code.

32 Revised Law

33 Sec. 1501.258. FORMS. (a) The commissioner shall:

34 (1) prescribe the benefits section of the catastrophic
35 care health benefit plan and the basic coverage health benefit plan
36 policy forms in accordance with Section 1501.253; and

37 (2) develop prototype policies for each of the health
38 benefit plans that include all contractual provisions required to
39 produce an entire contract in accordance with this code.

40 (b) With regard to each portion of the policy form for the
41 catastrophic care health benefit plan or the basic coverage health
42 benefit plan, other than the benefits section, a small employer
43 health benefit plan issuer shall comply with:

44 (1) Chapter 1701 as it relates to policy form
45 approval; and

46 (2) Chapter 1271 as it relates to evidence of coverage

1 approval.

2 (c) A small employer health benefit plan issuer may not
3 offer the catastrophic care health benefit plan or the basic
4 coverage health benefit plan through a policy form or evidence of
5 coverage that does not comply with this chapter. (V.T.I.C. Art.
6 26.43, Subsec. (a); Art. 26.44A, Subsec. (a) (part).)

7 Source Law

8 Art. 26.43. (a) The commissioner shall
9 promulgate the benefits section of the catastrophic
10 care benefit plan and the basic coverage benefit plan
11 policy forms in accordance with Article 26.44A of this
12 code and shall develop prototype policies for each of
13 the benefit plans. For all other portions of these
14 policy forms, a small employer carrier shall comply
15 with Article 3.42 of this code as it relates to policy
16 form approval and with the Texas Health Maintenance
17 Organization Act (Article 20A.01 et seq., Vernon's
18 Texas Insurance Code) as it relates to approval of an
19 evidence of coverage. A small employer carrier may not
20 offer these benefit plans through a policy form or
21 evidence of coverage that does not comply with this
22 chapter.

23 Art. 26.44A. (a) . . . The commissioner shall
24 develop prototype policies for use by small employer
25 carriers that include all contractual provisions
26 required to produce an entire contract in accordance
27 with this article and this code.

28 Revisor's Note

29 Subsection (a), V.T.I.C. Article 26.43, requires
30 a small employer health benefit plan issuer to comply
31 with "the Texas Health Maintenance Organization Act
32 (Article 20A.01 et seq., Vernon's Texas Insurance
33 Code) as it relates to approval of an evidence of
34 coverage." The relevant provisions of the Texas
35 Health Maintenance Organization Act relating to
36 approval of an evidence of coverage are revised in
37 Chapter 1271 of this code, and the revised law is
38 drafted accordingly.

39 Revised Law

40 Sec. 1501.259. RIDERS; FILING WITH COMMISSIONER. (a) A
41 small employer health benefit plan issuer shall file with the
42 commissioner, in a form and manner prescribed by the commissioner,
43 each rider to a small employer health benefit plan to be used by the

1 issuer, as authorized by Section 1501.252.

2 (b) A small employer health benefit plan issuer may use a
3 rider filed under this section after the 30th day after the date the
4 rider is filed unless the commissioner disapproves its use.

5 (c) The commissioner, after notice and an opportunity for a
6 hearing, may disapprove the continued use of a rider by a small
7 employer health benefit plan issuer if the rider does not meet the
8 requirements of this chapter and other applicable statutes.
9 (V.T.I.C. Art. 26.44.)

10 Source Law

11 Art. 26.44. (a) A small employer carrier shall
12 file with the commissioner, in a form and manner
13 prescribed by the commissioner, riders to the small
14 employer health benefit plans as allowed under Article
15 26.42 of this code to be used by the small employer
16 carrier. A small employer carrier may use a rider
17 filed under this article after the 30th day after the
18 date the rider is filed unless the commissioner
19 disapproves its use.

20 (b) The commissioner, after notice and an
21 opportunity for a hearing, may disapprove the
22 continued use by a small employer carrier of a rider if
23 the rider does not meet the requirements of this
24 chapter and other applicable statutes.

25 Revised Law

26 Sec. 1501.260. PLAIN LANGUAGE REQUIRED. (a) A health
27 benefit plan issuer may not issue and the commissioner may not
28 approve a health benefit plan certificate or policy or a rider to a
29 health benefit plan certificate or policy unless it is written in
30 plain language.

31 (b) Each provision of a health benefit plan certificate or
32 policy or a rider to a health benefit plan certificate or policy
33 relating to renewal of coverage, conditions of coverage, or per
34 occurrence or aggregate dollar limitations on coverage must be
35 clearly explained in plain language.

36 (c) A health benefit plan issuer may not use and the
37 commissioner may not approve a health benefit plan application form
38 unless it is written in plain language.

39 (d) Subsections (a)-(c) do not apply if the specific
40 language to be used is required by federal law or state statute or

1 by rules implementing federal law.

2 (e) For purposes of Subsections (a)-(d), a health benefit
3 plan certificate or policy, a rider to or a provision of a health
4 benefit plan certificate or policy, or a health benefit plan
5 application form is written in plain language if it achieves the
6 minimum score established by the commissioner on the Flesch reading
7 ease test or an equivalent test selected by the commissioner.

8 (f) This section does not apply to:

9 (1) a health benefit plan group master policy; or

10 (2) a policy application or enrollment form for a
11 health benefit plan group master policy. (V.T.I.C. Art. 26.43,
12 Subsecs. (b), (c), (d), (e), (f), (g).)

13 Source Law

14 (b) A health carrier may not issue and the
15 commissioner may not approve a health benefit plan
16 certificate or policy or a rider to a health benefit
17 plan certificate or policy unless it is written in
18 plain language.

19 (c) Each provision of a health benefit plan
20 certificate or policy or a rider to a health benefit
21 plan certificate or policy relating to renewal of
22 coverage, conditions of coverage, or per occurrence or
23 aggregate dollar limitations on coverage must be
24 clearly explained in plain language.

25 (d) A health carrier may not use and the
26 commissioner may not approve a health benefit plan
27 application form unless it is in plain language.

28 (e) Subsections (b) through (d) of this article
29 do not apply if the specific language to be used is
30 mandated by federal law or state statute or by rules
31 implementing federal law.

32 (f) For purposes of Subsections (b) through (e)
33 of this article, a health benefit plan certificate or
34 policy, a rider to or a provision of a health benefit
35 plan certificate or policy, or a health benefit plan
36 application form is written in plain language if it
37 achieves the minimum score established by the
38 commissioner on the Flesch reading ease test or an
39 equivalent test selected by the commissioner.

40 (g) The provisions of Subsections (b) through
41 (f) of this article requiring the use of plain language
42 do not apply to a health benefit plan group master
43 policy or to a policy application or enrollment form
44 for a health benefit plan group master policy.

45 [Sections 1501.261-1501.300 reserved for expansion]

46 SUBCHAPTER G. REINSURANCE FOR SMALL EMPLOYER HEALTH BENEFIT PLANS

47 Revised Law

48 Sec. 1501.301. DEFINITIONS. In this subchapter:

49 (1) "Board" means the board of directors of the Texas

1 Health Reinsurance System.

2 (2) "Plan of operation" means the plan of operation of
3 the system established under Section 1501.306.

4 (3) "Reinsured health benefit plan issuer" means a
5 small employer health benefit plan issuer that participates in the
6 system.

7 (4) "Risk-assuming health benefit plan issuer" means a
8 small employer health benefit plan issuer that does not participate
9 in the system.

10 (5) "System" means the Texas Health Reinsurance System
11 established under this subchapter. (V.T.I.C. Art. 26.02, Subdivs.
12 (4), (22), (27); Art. 26.02, Subdiv. (33), as amended Acts 77th
13 Leg., R.S., Ch. 823; Art. 26.02, Subdivs. (28), (32), as amended
14 Acts 77th Leg., R.S., Ch. 608.)

15 Source Law

16 Art. 26.02. In this chapter:

17 (4) "Board of directors" means the board
18 of directors of the Texas Health Reinsurance System.

19 (22) "Plan of operation" means the plan of
20 operation of the system established under Article
21 26.55 of this code.

22 (27) "Reinsured carrier" means a small
23 employer carrier participating in the system.

24 Art. 26.02. [as amended Acts 77th Leg., R.S., Ch.
25 823] In this chapter:

26 (33) "System" means the Texas Health
27 Reinsurance System established under Subchapter F of
28 this chapter.

29 Art. 26.02. [as amended Acts 77th Leg., R.S., Ch.
30 608] In this chapter:

31 (28) "Risk-assuming carrier" means a small
32 employer carrier that elects not to participate in the
33 system.

34 (32) "System" means the Texas Health
35 Reinsurance System established under Subchapter F of
36 this chapter.

37 Revisor's Note

38 Subdivision (27), V.T.I.C. Article 26.02,
39 defines "reinsured carrier." Subdivision (28),
40 V.T.I.C. Article 26.02, as amended by Chapter 608,

1 Acts of the 77th Legislature, Regular Session, 2001,
2 defines "risk-assuming carrier." Throughout this
3 subchapter, the revised law substitutes "reinsured
4 health benefit plan issuer" for "reinsured carrier"
5 and "risk-assuming health benefit plan issuer" for
6 "risk-assuming carrier" for the reason stated in
7 Revisor's Note (4) to Section 1501.002.

8 Revised Law

9 Sec. 1501.302. TEXAS HEALTH REINSURANCE SYSTEM. The Texas
10 Health Reinsurance System is a nonprofit entity administered by a
11 board of directors and subject to the supervision and control of the
12 commissioner. (V.T.I.C. Art. 26.53.)

13 Source Law

14 Art. 26.53. (a) The Texas Health Reinsurance
15 System is created as a nonprofit entity.

16 (b) The system is administered by a board of
17 directors and operates subject to the supervision and
18 control of the commissioner.

19 Revisor's Note

20 Subsection (a), V.T.I.C. Article 26.53, provides
21 that the Texas Health Reinsurance System "is created."
22 The revised law omits the reference to the creation of
23 the system because it has been executed.

24 Revised Law

25 Sec. 1501.303. SYSTEM BOARD OF DIRECTORS. (a) The board
26 of directors of the system is composed of:

27 (1) nine members appointed by the commissioner; and

28 (2) the commissioner or the commissioner's
29 representative, who serves as an ex officio member.

30 (b) Five of the appointed members must be representatives of
31 reinsured health benefit plan issuers selected from individuals
32 nominated by small employer health benefit plan issuers in this
33 state according to procedures developed by the commissioner.

34 (c) Four of the appointed members must represent the public.
35 A member representing the public may not:

36 (1) be an officer, director, or employee of an

1 insurance company, agency, agent, broker, solicitor, or adjuster or
2 any other business entity regulated by the department;

3 (2) be a person required to register under Chapter
4 305, Government Code; or

5 (3) be related to a person described by Subdivision
6 (1) or (2) within the second degree by affinity or consanguinity.

7 (d) Appointed members serve two-year terms expiring
8 December 31 of each odd-numbered year. A member's term continues
9 until a successor is appointed.

10 (e) A member of the board may not be compensated for serving
11 on the board but is entitled to reimbursement for actual expenses
12 incurred in performing functions as a member of the board as
13 provided by the General Appropriations Act. (V.T.I.C. Art. 26.54,
14 Subsecs. (a), (b), (c).)

15 Source Law

16 Art. 26.54. (a) The board of directors is
17 composed of nine members appointed by the
18 commissioner. The commissioner or the commissioner's
19 representative shall serve as an ex officio member.
20 Five members must be representatives of reinsured
21 carriers selected from individuals nominated by small
22 employer carriers in this state according to
23 procedures developed by the commissioner. Four
24 members must represent the general public. A member
25 representing the general public may not be:

26 (1) an officer, director, or employee of
27 an insurance company, agency, agent, broker,
28 solicitor, or adjuster or any other business entity
29 regulated by the department;

30 (2) a person required to register with the
31 Texas Ethics Commission under Chapter 305, Government
32 Code; or

33 (3) related to a person described by
34 Subdivision (1) or (2) of this subsection within the
35 second degree of affinity or consanguinity.

36 (b) The members appointed by the commissioner
37 serve two-year terms. The terms expire on December 31
38 of each odd-numbered year. A member's term continues
39 until a successor is appointed.

40 (c) A member of the board of directors may not be
41 compensated for serving on the board of directors but
42 is entitled to reimbursement for actual expenses
43 incurred in performing functions as a member of the
44 board of trustees as provided in the General
45 Appropriations Act.

46 Revisor's Note

47 Subsection (a)(2), V.T.I.C. Article 26.54,
48 refers to registration "with the Texas Ethics

1 Commission under Chapter 305, Government Code." The
2 revised law omits the reference to the Texas Ethics
3 Commission as unnecessary. Chapter 305, Government
4 Code, provides for registration only with that agency.

5 Revised Law

6 Sec. 1501.304. OPEN MEETINGS; PUBLIC INFORMATION. The
7 board is subject to:

8 (1) the open meetings law, Chapter 551, Government
9 Code; and

10 (2) the public information law, Chapter 552,
11 Government Code. (V.T.I.C. Art. 26.54, Subsec. (d).)

12 Source Law

13 (d) The board of directors is subject to the
14 open meetings law, Chapter 271, Acts of the 60th
15 Legislature, Regular Session, 1967 (Article 6252-17,
16 Vernon's Texas Civil Statutes), and the open records
17 law, Chapter 424, Acts of the 63rd Legislature,
18 Regular Session, 1973 (Article 6252-17a, Vernon's
19 Texas Civil Statutes).

20 Revisor's Note

21 (1) Subsection (d), V.T.I.C. Article 26.54,
22 refers to "the open meetings law, Chapter 271, Acts of
23 the 60th Legislature, Regular Session, 1967 (Article
24 6252-17, Vernon's Texas Civil Statutes)." That
25 statute was codified in 1993 as Chapter 551,
26 Government Code. The revised law is drafted
27 accordingly.

28 (2) Subsection (d), V.T.I.C. Article 26.54,
29 refers to "the open records law, Chapter 424, Acts of
30 the 63rd Legislature, Regular Session, 1973 (Article
31 6252-17a, Vernon's Texas Civil Statutes)." The
32 revised law substitutes a reference to the public
33 information law, Chapter 552, Government Code, for the
34 reason stated in the revisor's note to Section
35 1501.055.

36 Revised Law

37 Sec. 1501.305. BOARD MEMBER IMMUNITY. (a) A member of the

1 board is not liable for an act performed, or omission made, in good
2 faith in the performance of powers and duties under this
3 subchapter.

4 (b) A cause of action does not arise against a member of the
5 board for an act or omission described by Subsection (a). (V.T.I.C.
6 Art. 26.54, Subsec. (e).)

7 Source Law

8 (e) There is no liability on the part of, and no
9 cause of action of any nature arises against, a member
10 of the board of directors for action or omission
11 performed in good faith in the performance of powers
12 and duties under this subchapter.

13 Revised Law

14 Sec. 1501.306. SYSTEM PLAN OF OPERATION. (a) The board
15 shall submit to the commissioner a plan of operation and any
16 amendments to that plan necessary or suitable to ensure the fair,
17 reasonable, and equitable administration of the system.

18 (b) The commissioner, after notice and hearing, may approve
19 the plan of operation if the commissioner determines the plan:

20 (1) is suitable to ensure the fair, reasonable, and
21 equitable administration of the system; and

22 (2) provides for the sharing of system gains or losses
23 on an equitable and proportionate basis in accordance with this
24 subchapter.

25 (c) The plan of operation is effective on the written
26 approval of the commissioner.

27 (d) The plan of operation must:

28 (1) establish procedures for:

29 (A) handling and accounting for system assets and
30 money;

31 (B) making an annual fiscal report to the
32 commissioner;

33 (C) selecting an administering health benefit
34 plan issuer or third-party administrator and establishing the
35 powers and duties of the administering issuer or third-party
36 administrator;

1 (D) reinsuring risks in accordance with this
2 subchapter; and

3 (E) collecting assessments from reinsured health
4 benefit plan issuers to fund claims and administrative expenses
5 incurred or estimated to be incurred by the system, including the
6 imposition of penalties for late payment of an assessment; and

7 (2) provide for any additional matter necessary to
8 implement and administer the system. (V.T.I.C. Art. 26.55,
9 Subsecs. (a) (part), (c).)

10 Source Law

11 Art. 26.55. (a) . . . the board of directors
12 shall submit to the commissioner a plan of operation
13 and thereafter any amendments necessary or suitable to
14 ensure the fair, reasonable, and equitable
15 administration of the system. The commissioner, after
16 notice and hearing, may approve the plan of operation
17 if the commissioner determines the plan is suitable to
18 ensure the fair, reasonable, and equitable
19 administration of the system and provides for the
20 sharing of system gains or losses on an equitable and
21 proportionate basis in accordance with the provisions
22 of this subchapter. The plan of operation is effective
23 on the written approval of the commissioner.

24 (c) The plan of operation must:

25 (1) establish procedures for the handling
26 and accounting of system assets and money and for an
27 annual fiscal report to the commissioner;

28 (2) establish procedures for the selection
29 of an administering carrier or third-party
30 administrator and establish the powers and duties of
31 that administering carrier or third-party
32 administrator;

33 (3) establish procedures for reinsuring
34 risks in accordance with the provisions of this
35 article;

36 (4) establish procedures for collecting
37 assessments from reinsured carriers to fund claims and
38 administrative expenses incurred or estimated to be
39 incurred by the system, including the imposition of
40 penalties for late payment of an assessment; and

41 (5) provide for any additional matters
42 necessary for the implementation and administration of
43 the system.

44 Revisor's Note

45 Subsection (a), V.T.I.C. Article 26.55, in part
46 requires the board of directors of the Texas Health
47 Reinsurance System to submit a plan of operation for
48 the system to the commissioner of insurance "[n]ot
49 later than the 180th day after the date on which a

1 majority of the members of the board of directors have
2 been appointed." The revised law omits this provision
3 as executed; it is a transition provision that applies
4 only to the initial board. V.T.I.C. Articles
5 26.51-26.62, revised as this subchapter, were enacted
6 in 1993. Although Subsection (b), V.T.I.C. Article
7 26.54, revised as Section 1501.303(d), provides that
8 appointed members of the board of directors serve
9 two-year terms that expire December 31 of each
10 odd-numbered year, it also provides that a member's
11 term continues until a successor is appointed. Thus,
12 after the appointment of a majority of the initial
13 members, there will always be "a majority of members"
14 serving on the board.

15 Subsection (b), V.T.I.C. Article 26.55, provides
16 that if the board of directors "fails to timely submit
17 a suitable plan of operation, the commissioner, after
18 notice and hearing, shall adopt a temporary plan of
19 operation." Again, this is a transition provision
20 that applies only to the initial board, and the revised
21 law omits it as executed.

22 The omitted law reads:

23 Art. 26.55. (a) Not later than the
24 180th day after the date on which a majority
25 of the members of the board of directors
26 have been appointed, [the board of
27 directors shall submit to the commissioner
28 a plan of operation]

29 (b) If the board of directors fails
30 to timely submit a suitable plan of
31 operation, the commissioner, after notice
32 and hearing, shall adopt a temporary plan of
33 operation. The commissioner shall amend or
34 rescind any plan adopted under this
35 subsection at the time a plan of operation
36 is submitted by the board of directors and
37 approved by the commissioner.

38 Revised Law

39 Sec. 1501.307. SYSTEM POWERS. (a) The system has the
40 general powers and authority granted under state law to an insurer
41 or a health maintenance organization authorized to engage in

1 business, except that the system may not directly issue a health
2 benefit plan.

3 (b) The system may:

4 (1) enter into contracts necessary or proper to
5 implement this subchapter, including, with the commissioner's
6 approval, contracts with similar programs of other states for the
7 joint performance of common functions or with persons or other
8 organizations for the performance of administrative functions;

9 (2) sue or be sued, including taking legal action
10 necessary or proper to recover assessments and penalties for, on
11 behalf of, or against the system or a reinsured health benefit plan
12 issuer;

13 (3) take legal action necessary to avoid the payment
14 of improper claims against the system;

15 (4) issue reinsurance contracts in accordance with
16 this subchapter;

17 (5) establish guidelines, conditions, and procedures
18 for reinsuring risks under the plan of operation;

19 (6) establish actuarial functions as appropriate for
20 the operation of the system;

21 (7) assess reinsured health benefit plan issuers in
22 accordance with Sections 1501.319-1501.323;

23 (8) appoint appropriate legal, actuarial, and other
24 committees necessary to provide technical assistance in:

25 (A) the operation of the system;

26 (B) policy and other contract design; and

27 (C) any other function within the authority of
28 the system; and

29 (9) borrow money for a period not to exceed one year to
30 accomplish the purposes of the system.

31 (c) The system is exempt from all taxes. (V.T.I.C. Art.
32 26.56 (part).)

33 Source Law

34 Art. 26.56. The system has the general powers

1 and authority granted under the laws of this state to
2 insurance companies and health maintenance
3 organizations licensed to transact business, except
4 that the system may not directly issue health benefit
5 plans. The system is exempt from all taxes. The
6 system may:

7 (1) enter into contracts necessary or
8 proper to carry out the provisions and purposes of this
9 subchapter and may, with the approval of the
10 commissioner, enter into contracts with similar
11 programs of other states for the joint performance of
12 common functions or with persons or other
13 organizations for the performance of administrative
14 functions;

15 (2) sue or be sued, including taking legal
16 actions necessary or proper to recover assessments and
17 penalties for, on behalf of, or against the system or a
18 reinsured carrier;

19 (3) take legal action necessary to avoid
20 the payment of improper claims against the system;

21 (4) issue reinsurance contracts in
22 accordance with the requirements of this subchapter;

23 (5) establish guidelines, conditions, and
24 procedures for reinsuring risks under the plan of
25 operation;

26 (6) establish actuarial functions as
27 appropriate for the operation of the system;

28 (7) assess reinsured carriers in
29 accordance with the provisions of Article 26.60 of
30 this code and . . . ;

31 (8) appoint appropriate legal, actuarial,
32 and other committees as necessary to provide technical
33 assistance in the operation of the system, policy and
34 other contract design, and any other function within
35 the authority of the system; and

36 (9) borrow money for a period not to exceed
37 one year to effect the purposes of the system, provided
38 that

39 Revisor's Note

40 V.T.I.C. Article 26.56 refers to "insurance
41 companies and health maintenance organizations
42 licensed to transact business." The revised law
43 substitutes "authorized to engage in business" for the
44 quoted language for consistency with other terminology
45 used throughout this code.

46 Revised Law

47 Sec. 1501.308. SYSTEM NOTES AS LEGAL INVESTMENT FOR SMALL
48 EMPLOYER HEALTH BENEFIT PLAN ISSUER. A note or other evidence of
49 indebtedness of the system that is not in default is a legal
50 investment for a small employer health benefit plan issuer and may
51 be carried as an admitted asset. (V.T.I.C. Art. 26.56 (part).)

52 Source Law

53 Art. 26.56. . . .

1 (9) . . . any notes or other evidence of
2 indebtedness of the system not in default shall be
3 legal investments for small employer carriers and may
4 be carried as admitted assets.

5 Revised Law

6 Sec. 1501.309. SYSTEM AUDIT. (a) The transactions of the
7 system are subject to audit by the state auditor in accordance with
8 Chapter 321, Government Code.

9 (b) The state auditor shall report the cost of each audit
10 conducted under this section to the board and the comptroller, and
11 the board shall remit that amount to the comptroller. (V.T.I.C.
12 Art. 26.57.)

13 Source Law

14 Art. 26.57. (a) The transactions of the system
15 are subject to audit by the state auditor in accordance
16 with Chapter 321, Government Code.

17 (b) The state auditor shall report the cost of
18 each audit conducted under this article to the board of
19 directors and the comptroller, and the board of
20 directors shall remit that amount to the comptroller
21 for deposit to the general revenue fund.

22 Revisor's Note

23 Subsection (b), V.T.I.C. Article 26.57, provides
24 that the board of directors shall remit a specified
25 amount to the comptroller "for deposit to the general
26 revenue fund." The revised law omits the quoted
27 language as unnecessary. Section 404.094, Government
28 Code (State Funds Reform Act), requires all money,
29 including the referenced amount, collected or received
30 by a state agency to be deposited to the credit of the
31 general revenue fund if another fund or account is not
32 specified in the law authorizing the collection or
33 receipt. It is unnecessary to repeat that requirement
34 in this chapter.

35 Revised Law

36 Sec. 1501.310. ELECTION OF STATUS. (a) Each small employer
37 health benefit plan issuer shall notify the commissioner of the
38 issuer's election to operate as a risk-assuming health benefit plan
39 issuer or as a reinsured health benefit plan issuer. An issuer that

1 elects to operate as a risk-assuming health benefit plan issuer
2 shall file an application in accordance with Section 1501.312.

3 (b) A small employer health benefit plan issuer's election
4 under this section is effective until the fifth anniversary of the
5 date of the election.

6 (c) The commissioner may permit a small employer health
7 benefit plan issuer to modify its election at any time for good
8 cause shown. (V.T.I.C. Art. 26.51, Subsecs. (a), (b).)

9 Source Law

10 Art. 26.51. (a) Each small employer carrier
11 shall notify the commissioner of the carrier's
12 election to operate as a risk-assuming carrier or a
13 reinsured carrier. A small employer carrier seeking
14 to operate as a risk-assuming carrier shall make an
15 application under Article 26.52 of this code.

16 (b) A small employer carrier's election under
17 Subsection (a) of this article is effective until the
18 fifth anniversary of the election. The commissioner
19 may permit a small employer carrier to modify its
20 decision at any time for good cause shown.

21 Revised Law

22 Sec. 1501.311. CHANGE IN STATUS. (a) The commissioner
23 shall establish an application process for a small employer health
24 benefit plan issuer that elects to change its status under this
25 subchapter.

26 (b) A reinsured health benefit plan issuer that elects to
27 change its status to operate as a risk-assuming health benefit plan
28 issuer may not continue to reinsure a small employer health benefit
29 plan with the system. The issuer shall pay a prorated assessment
30 based on business issued as a reinsured health benefit plan issuer
31 for the portion of the year the business was reinsured. (V.T.I.C.
32 Art. 26.51, Subsecs. (c), (d).)

33 Source Law

34 (c) The commissioner shall establish an
35 application process for small employer carriers
36 seeking to change their status under this article.

37 (d) A reinsured carrier that elects to change
38 its status to operate as a risk-assuming carrier may
39 not continue to reinsure a small employer health
40 benefit plan with the system. The carrier shall pay a
41 prorated assessment based on business issued as a
42 reinsured carrier for any portion of the year that the
43 business was reinsured.

1 Revised Law

2 Sec. 1501.312. APPLICATION TO OPERATE AS RISK-ASSUMING
3 HEALTH BENEFIT PLAN ISSUER. (a) A small employer health benefit
4 plan issuer may apply to operate as a risk-assuming health benefit
5 plan issuer by filing an application with the commissioner in a form
6 and manner prescribed by the commissioner.

7 (b) In evaluating an application, the commissioner shall
8 consider the small employer health benefit plan issuer's:

9 (1) financial condition;

10 (2) history of rating and underwriting small employer
11 groups;

12 (3) commitment to market fairly to all small employers
13 in the state or in the issuer's established geographic service
14 area; and

15 (4) experience managing the risk of small employer
16 groups.

17 (c) The commissioner shall provide public notice of an
18 application and shall provide at least a 60-day period for public
19 comment before making a decision on the application. If the
20 commissioner does not act on the application before the 90th day
21 after the date the commissioner receives the application, the
22 issuer may request and the commissioner shall grant a hearing.

23 (V.T.I.C. Art. 26.52, Subsecs. (a), (b), (c).)

24 Source Law

25 Art. 26.52. (a) A small employer carrier may
26 apply to become a risk-assuming carrier by filing an
27 application with the commissioner in a form and manner
28 prescribed by the commissioner.

29 (b) In evaluating an application filed under
30 Subsection (a) of this article, the commissioner shall
31 consider the small employer carrier's:

32 (1) financial condition;

33 (2) history of rating and underwriting
34 small employer groups;

35 (3) commitment to market fairly to all
36 small employers in the state or in its established
37 geographic service area; and

38 (4) experience managing the risk of small
39 employer groups.

40 (c) The commissioner shall provide public
41 notice of an application by a small employer carrier to
42 be a risk-assuming carrier and shall provide at least a
43 60-day period for public comment before making a

1 decision on the application. If the application is not
2 acted on before the 90th day after the date the
3 commissioner received the application, the carrier may
4 request and the commissioner shall grant a hearing.

5 Revised Law

6 Sec. 1501.313. RESCISSION OF APPROVAL TO OPERATE AS
7 RISK-ASSUMING HEALTH BENEFIT PLAN ISSUER. The commissioner, after
8 notice and hearing, may rescind approval to operate as a
9 risk-assuming health benefit plan issuer if the commissioner finds
10 that the issuer:

11 (1) is not financially able to support the assumption
12 of risk from issuing coverage to small employers without the
13 protection provided by the system;

14 (2) has failed to market fairly to all small employers
15 in the state or in the issuer's established geographic service
16 area; or

17 (3) has failed to provide coverage to eligible small
18 employers. (V.T.I.C. Art. 26.52, Subsec. (d).)

19 Source Law

20 (d) The commissioner, after notice and hearing,
21 may rescind the approval granted to a risk-assuming
22 carrier under this article if the commissioner finds
23 that the carrier:

24 (1) is not financially able to support the
25 assumption of risk from issuing coverage to small
26 employers without the protection afforded by the
27 system;

28 (2) has failed to market fairly to all
29 small employers in the state or its established
30 geographic service area; or

31 (3) has failed to provide coverage to
32 eligible small employers.

33 Revised Law

34 Sec. 1501.314. REINSURANCE. (a) A small employer health
35 benefit plan issuer may reinsure risks covered under a small
36 employer health benefit plan with the system as provided by this
37 subchapter.

38 (b) The system shall reinsure the level of coverage provided
39 under the small employer health benefit plan.

40 (c) A small employer health benefit plan issuer may
41 reinsure:

42 (1) an entire small employer group not later than the

1 60th day after the date the group's coverage under the small
2 employer health benefit plan takes effect;

3 (2) an eligible employee of a small employer or the
4 employee's dependent not later than the 60th day after the date the
5 person's coverage takes effect; or

6 (3) a newly eligible employee of a reinsured small
7 employer group, the employee's dependent, or an individual covered
8 under the small employer health benefit plan not later than the 60th
9 day after the date the individual's coverage takes effect.

10 (V.T.I.C. Art. 26.58, Subsecs. (a), (b), (c).)

11 Source Law

12 Art. 26.58. (a) A small employer carrier may
13 reinsure risks covered under the small employer health
14 benefit plans with the system as provided by this
15 article.

16 (b) The system shall reinsure the level of
17 coverage provided under the small employer health
18 benefit plans.

19 (c) A small employer carrier may reinsure an
20 entire small employer group not later than the 60th day
21 after the date on which the group's coverage under the
22 small employer health benefit plans takes effect. A
23 small employer carrier may reinsure an eligible
24 employee of a small employer or the employee's
25 dependent not later than the 60th day after the date on
26 which that individual's coverage takes effect. A newly
27 eligible employee or dependent of a reinsured small
28 employer group or an individual covered under the
29 small employer health benefit plans may be reinsured
30 not later than the 60th day after the date on which
31 that individual's coverage takes effect.

32 Revised Law

33 Sec. 1501.315. LIMITS ON REINSURANCE. (a) The system may
34 not reimburse a reinsured health benefit plan issuer for the claims
35 of a reinsured individual until the issuer has incurred an initial
36 level of claims of \$5,000 in a calendar year for that individual for
37 benefits covered by the system. In addition, the reinsured health
38 benefit plan issuer is responsible for 10 percent of the next
39 \$50,000 of benefit payments during a calendar year, and the system
40 shall reinsure the remainder. A reinsured health benefit plan
41 issuer's liability to a reinsured individual may not exceed a
42 maximum of \$10,000 in a calendar year.

43 (b) The board annually shall adjust the initial level of

1 claims and the maximum liability to be retained by a reinsured
2 health benefit plan issuer under Subsection (a) to reflect
3 increases in:

4 (1) costs; and

5 (2) the use of small employer health benefit plans in
6 this state.

7 (c) An adjustment under Subsection (b) may not be less than
8 the annual change in the medical component of the Consumer Price
9 Index for All Urban Consumers published by the Bureau of Labor
10 Statistics of the United States Department of Labor unless the
11 board proposes and the commissioner approves a lower adjustment
12 factor. (V.T.I.C. Art. 26.58, Subsecs. (d), (e).)

13 Source Law

14 (d) The system may not reimburse a reinsured
15 carrier for the claims of any reinsured individual
16 until the carrier has incurred an initial level of
17 claims for that individual in a calendar year of \$5,000
18 for benefits covered by the system. In addition, the
19 reinsured carrier is responsible for 10 percent of the
20 next \$50,000 of benefit payments during a calendar
21 year, and the system shall reinsure the remainder. A
22 reinsured carrier's liability to any insured
23 individual may not exceed a maximum of \$10,000 in any
24 one calendar year for that individual.

25 (e) The board of directors annually shall adjust
26 the initial level of claims and the maximum to be
27 retained by the carrier established under Subsection
28 (d) of this article to reflect increases in costs and
29 in use for small employer health benefit plans in this
30 state. The adjustment may not be less than the annual
31 change in the medical component of the Consumer Price
32 Index for All Urban Consumers published by the Bureau
33 of Labor Statistics of the United States Department of
34 Labor unless the board of directors proposes and the
35 commissioner approves a lower adjustment factor.

36 Revised Law

37 Sec. 1501.316. TERMINATION OF REINSURANCE. A small
38 employer health benefit plan issuer may terminate reinsurance with
39 the system for one or more reinsured employees or dependents of
40 employees of a small employer on a contract anniversary of the small
41 employer health benefit plan. (V.T.I.C. Art. 26.58, Subsec. (f).)

42 Source Law

43 (f) A small employer carrier may terminate
44 reinsurance with the system for one or more of the
45 reinsured employees or dependents of employees of a
46 small employer on a contract anniversary of the small

1 employer health benefit plans.

2 Revised Law

3 Sec. 1501.317. APPLICATION OF MANAGED CARE PROCEDURES.

4 Except as provided by the plan of operation, a reinsured health
5 benefit plan issuer shall apply consistently with respect to
6 reinsured and nonreinsured business all managed care procedures,
7 including utilization review, individual case management,
8 preferred provider provisions, and other managed care provisions or
9 methods of operation. (V.T.I.C. Art. 26.58, Subsec. (g).)

10 Source Law

11 (g) Except as provided in the plan of operation,
12 a reinsured carrier shall apply consistently with
13 respect to reinsured and nonreinsured business all
14 managed care procedures, including utilization
15 review, individual case management, preferred
16 provider provisions, and other managed care provisions
17 or methods of operation.

18 Revised Law

19 Sec. 1501.318. PREMIUM RATES FOR REINSURANCE. (a) As part
20 of the plan of operation, the board shall adopt a method to
21 determine premium rates to be charged by the system for reinsuring
22 small employer groups and individuals under this subchapter.

23 (b) The method adopted must:

24 (1) include a classification system for small employer
25 groups that reflects the variations in premium rates allowed by
26 this chapter; and

27 (2) provide for the development of base reinsurance
28 premium rates that reflect the allowable variations.

29 (c) Subject to approval by the commissioner, the board shall
30 establish the base reinsurance premium rates at levels that
31 reasonably approximate the gross premiums charged to small
32 employers by small employer health benefit plan issuers for small
33 employer health benefit plans, adjusted to reflect retention levels
34 required under this subchapter.

35 (d) The board shall periodically review the method adopted
36 under this section, including the classification system and any
37 rating factors, to ensure that the method reasonably reflects the

1 claims experience of the system. The board may propose changes to
2 the method. Any changes are subject to approval by the
3 commissioner.

4 (e) An entire small employer group may be reinsured at a
5 rate that is 1-1/2 times the base reinsurance premium rate for that
6 group. An eligible employee of a small employer or the employee's
7 dependent covered under a small employer health benefit plan may be
8 reinsured at a rate that is five times the base reinsurance premium
9 rate for that individual.

10 (f) The board may consider adjustments to the premium rates
11 charged by the system to reflect the use of effective cost
12 containment and managed care arrangements. (V.T.I.C. Art. 26.59.)

13 Source Law

14 Art. 26.59. (a) As part of the plan of
15 operation, the board of directors shall adopt a method
16 to determine premium rates to be charged by the system
17 for reinsuring small employer groups and individuals
18 under this subchapter.

19 (b) The method adopted must include
20 classification systems for small employer groups that
21 reflect the variations in premium rates allowed in
22 this chapter and must provide for the development of
23 base reinsurance premium rates that reflect the
24 allowable variations. The base reinsurance premium
25 rates shall be established by the board of directors,
26 subject to the approval of the board, and shall be set
27 at levels that reasonably approximate the gross
28 premiums charged to small employers by small employer
29 carriers for the small employer health benefit plans,
30 adjusted to reflect retention levels required under
31 this subchapter. The board of directors periodically
32 shall review the method adopted under this subsection,
33 including the classification system and any rating
34 factors, to ensure that the method reasonably reflects
35 the claim experience of the system. The board of
36 directors may propose changes to the method. The
37 changes are subject to the approval of the board.

38 (c) An entire small employer group may be
39 reinsured at a rate that is 1 1/2 times the base
40 reinsurance premium rate for that group. An eligible
41 employee of a small employer or the employee's
42 dependent covered under the small employer health
43 benefit plans may be reinsured at a rate that is five
44 times the base reinsurance premium rate for that
45 individual.

46 (d) The board of directors may consider
47 adjustments to the premium rates charged by the system
48 to reflect the use of effective cost containment and
49 managed care arrangements.

50 Revisor's Note

51 Subsection (b), V.T.I.C. Article 26.59, provides

1 that the base reinsurance premium rates under the
2 Texas Health Reinsurance System "shall be established
3 by the board of directors, subject to the approval of
4 the board," and that "[t]he board of directors may
5 propose changes to the method [of determining premium
6 rates,] . . . subject to the approval of the board."
7 The references to the "board" that may approve premium
8 rates and changes to the method of determining rates
9 are references to the State Board of Insurance.
10 Accordingly, the revised law substitutes references to
11 the commissioner for the reason stated in Revisor's
12 Note (1) to Section 1501.211.

13 Revised Law

14 Sec. 1501.319. DETERMINATION OF NET LOSS. (a) Not later
15 than March 1 of each year, the board shall determine the system's
16 net loss for the preceding calendar year, including administrative
17 expenses and incurred losses for the year, and report the net loss
18 to the commissioner.

19 (b) In determining the net loss, the board shall take into
20 account investment income and other appropriate gains and losses.
21 (V.T.I.C. Art. 26.60, Subsec. (a) (part).)

22 Source Law

23 Art. 26.60. (a) Not later than March 1 of each
24 year, the board of directors shall determine and
25 report to the commissioner the system net loss for the
26 previous calendar year, including administrative
27 expenses and incurred losses for the year, taking into
28 account investment income and other appropriate gains
29 and losses. . . .

30 Revised Law

31 Sec. 1501.320. ASSESSMENTS TO RECOVER NET LOSSES. (a) The
32 board shall recover any net loss of the system by assessing each
33 reinsured health benefit plan issuer an amount determined annually
34 by the board based on information in annual statements and other
35 reports required by and filed with the board.

36 (b) The board shall establish, as part of the plan of
37 operation, a formula by which to make assessments against reinsured

1 health benefit plan issuers. With the approval of the
2 commissioner, the board may periodically change the assessment
3 formula as appropriate. The board shall base the assessment
4 formula on each reinsured issuer's share of:

5 (1) the total premiums earned in the preceding
6 calendar year from small employer health benefit plans delivered or
7 issued for delivery by reinsured health benefit plan issuers to
8 small employer groups in this state; and

9 (2) the premiums earned in the preceding calendar year
10 from newly issued small employer health benefit plans delivered or
11 issued for delivery during the calendar year by reinsured health
12 benefit plan issuers to small employer groups in this state.

13 (V.T.I.C. Art. 26.60, Subsec. (a) (part).)

14 Source Law

15 (a) . . . Any net loss for the year must be
16 recouped by assessments on reinsured carriers. Each
17 reinsured carrier's assessment shall be determined
18 annually by the board of directors based on annual
19 statements and other reports required by the board of
20 directors and filed with that board. The board of
21 directors shall establish, as part of the plan of
22 operation, a formula by which to make assessments
23 against reinsured carriers. With the approval of the
24 commissioner, the board of directors may change the
25 assessment formula from time to time as appropriate.
26 The board of directors shall base the assessment
27 formula on each reinsured carrier's share of:

28 (1) the total premiums earned in the
29 preceding calendar year from the small employer health
30 benefit plans delivered or issued for delivery by
31 reinsured carriers to small employer groups in this
32 state; and

33 (2) the premiums earned in the preceding
34 calendar year from newly issued small employer health
35 benefit plans delivered or issued for delivery during
36 the calendar year by reinsured carriers to small
37 employer groups in this state.

38 Revised Law

39 Sec. 1501.321. LIMITS ON ASSESSMENTS. (a) The formula
40 established under Section 1501.320(b) may not result in an
41 assessment for a reinsured health benefit plan issuer that is less
42 than 50 percent or more than 150 percent of an amount based on the
43 proportion of the total premiums earned in the preceding calendar
44 year from small employer health benefit plans delivered or issued
45 for delivery to small employer groups in this state by that issuer

1 to the total premiums earned in the preceding calendar year from
2 small employer health benefit plans delivered or issued for
3 delivery to small employer groups in this state by all reinsured
4 health benefit plan issuers.

5 (b) In determining assessments, the board may not consider
6 premiums earned by a reinsured health benefit plan issuer that are
7 less than an amount determined by the board to justify the cost of
8 collecting an assessment based on those premiums. (V.T.I.C. Art.
9 26.60, Subsec. (b).)

10 Source Law

11 (b) The formula established under Subsection
12 (a) of this article may not result in an assessment
13 share for a reinsured carrier that is less than 50
14 percent or more than 150 percent of an amount based on
15 the proportion of the total premium earned in the
16 preceding calendar year from the small employer health
17 benefit plans delivered or issued for delivery to
18 small employer groups in this state by that reinsured
19 carrier to the total premiums earned in the preceding
20 calendar year from small employer health benefit plans
21 delivered or issued for delivery to small employer
22 groups in this state by all reinsured carriers.
23 Premiums earned by a reinsured carrier that are less
24 than an amount determined by the board of directors to
25 justify the cost of collection of an assessment based
26 on those premiums may not be considered by the board of
27 directors in determining assessments.

28 Revised Law

29 Sec. 1501.322. ADJUSTMENT TO ASSESSMENTS ON FEDERALLY
30 QUALIFIED HEALTH MAINTENANCE ORGANIZATIONS. With the
31 commissioner's approval, the board may adjust the formula
32 established under Section 1501.320(b) for a reinsured health
33 benefit plan issuer that is an approved health maintenance
34 organization that is federally qualified under Title XIII, Public
35 Health Service Act (42 U.S.C. Section 300e et seq.), to the extent
36 that any restriction is imposed on that issuer that is not imposed
37 on other issuers. (V.T.I.C. Art. 26.60, Subsec. (c).)

38 Source Law

39 (c) With the approval of the commissioner, the
40 board of directors may adjust the assessment formula
41 for reinsured carriers that are approved health
42 maintenance organizations that are federally
43 qualified under Subchapter XI, Public Health Service
44 Act (42 U.S.C. Section 300e et seq.), to the extent
45 that any restrictions are imposed on those health

1 maintenance organizations that are not imposed on
2 other health carriers.

3 Revised Law

4 Sec. 1501.323. ADVANCE INTERIM ASSESSMENTS. (a) The
5 system may make advance interim assessments as reasonable and
6 necessary for organizational and interim operating expenses.

7 (b) After the end of the fiscal year, the system shall
8 credit an interim assessment made under this section as an offset
9 against regular assessments due. (V.T.I.C. Art. 26.56 (part).)

10 Source Law

11 Art. 26.56. . . . The system may:

12 . . .
13 (7) . . . make advance interim
14 assessments as may be reasonable and necessary for
15 organizational and interim operating expenses,
16 provided that any interim assessments shall be
17 credited as offsets against regular assessments due
18 after the close of the fiscal year;
19 . . .

20 Revised Law

21 Sec. 1501.324. LIMIT ON TOTAL ASSESSMENTS. The maximum
22 assessment amount payable for a calendar year may not exceed five
23 percent of the total premiums earned in the preceding calendar year
24 from small employer health benefit plans delivered or issued for
25 delivery by reinsured health benefit plan issuers in this state.
26 (V.T.I.C. Art. 26.61, Subsec. (f).)

27 Source Law

28 (f) The maximum assessment amount payable for a
29 calendar year may not exceed five percent of the total
30 premiums earned in the preceding calendar year from
31 small employer health benefit plans delivered or
32 issued for delivery by reinsured carriers in this
33 state.

34 Revised Law

35 Sec. 1501.325. ESTIMATE OF ASSESSMENTS; EVALUATION AND
36 PROTECTION OF SYSTEM. (a) Not later than March 1 of each year,
37 the board shall file with the commissioner an estimate of the
38 assessments necessary to fund the losses for small employer groups
39 incurred by the system during the preceding calendar year.

40 (b) If the board determines that the necessary assessments
41 exceed five percent of the total premiums earned in the preceding

1 calendar year from small employer health benefit plans delivered or
2 issued for delivery by reinsured health benefit plan issuers to
3 small employer groups in this state, the board shall evaluate the
4 operation of the system and shall report its findings, including
5 any recommendations for changes to the plan of operation, to the
6 commissioner not later than April 1 of the year following the
7 calendar year in which the losses were incurred. The evaluation
8 must:

9 (1) include an estimate of future assessments; and

10 (2) consider:

11 (A) the administrative costs of the system;

12 (B) the appropriateness of the premiums charged;

13 (C) the level of health benefit plan issuer
14 retention under the system; and

15 (D) the costs of coverage for small employer
16 groups.

17 (c) If the board fails to timely file a report required by
18 Subsection (b), the commissioner may:

19 (1) evaluate the operations of the system; and

20 (2) implement amendments to the plan of operation that
21 the commissioner considers necessary to reduce future losses and
22 assessments.

23 (d) A reinsured health benefit plan issuer may not write
24 small employer health benefit plans on a guaranteed issue basis
25 during a calendar year if the assessment amount payable for the
26 preceding calendar year is at least five percent of the total
27 premiums earned in that calendar year from small employer health
28 benefit plans delivered or issued for delivery by reinsured health
29 benefit plan issuers in this state.

30 (e) A reinsured health benefit plan issuer may not write
31 small employer health benefit plans on a guaranteed issue basis
32 after the board determines that the expected loss from the
33 reinsurance system for a year will exceed the total amount of
34 assessments payable at a rate of five percent of the total premiums

1 earned for the preceding calendar year. A reinsured health benefit
2 plan issuer may not resume writing small employer health benefit
3 plans on a guaranteed issue basis until the board determines that
4 the expected loss will be less than the maximum established by this
5 subsection. (V.T.I.C. Art. 26.61, Subsecs. (a), (b), (c), (d),
6 (e).)

7 Source Law

8 Art. 26.61. (a) Not later than March 1 of each
9 year, the board of directors shall file with the
10 commissioner an estimate of the assessments necessary
11 to fund the losses for small employer groups incurred
12 by the system during the previous calendar year.

13 (b) If the board of directors determines that
14 the necessary assessments exceed five percent of the
15 total premiums earned in the previous calendar year
16 from small employer health benefit plans delivered or
17 issued for delivery by reinsured carriers to small
18 employer groups in this state, the board of directors
19 shall evaluate the operation of the system and shall
20 report its findings, including any recommendations for
21 changes to the plan of operation, to the commissioner
22 not later than April 1 of the year following the
23 calendar year in which the losses were incurred. The
24 evaluation must include an estimate of future
25 assessments and must consider the administrative costs
26 of the system, the appropriateness of the premiums
27 charged, the level of insurer retention under the
28 system, and the costs of coverage for small employer
29 groups.

30 (c) If the board of directors fails to timely
31 file a report, the commissioner may evaluate the
32 operations of the system and may implement amendments
33 to the plan of operation as considered necessary by the
34 commissioner to reduce future losses and assessments.

35 (d) Reinsured carriers may not write small
36 employer health benefit plans on a guaranteed issue
37 basis during a calendar year if the assessment amount
38 payable for the previous calendar year is at least five
39 percent of the total premiums earned in that calendar
40 year from small employer health benefit plans
41 delivered or issued for delivery by reinsured carriers
42 in this state.

43 (e) Reinsured carriers may not write small
44 employer health benefit plans on a guaranteed issue
45 basis after the board of directors determines that the
46 expected loss from the reinsurance system for a year
47 will exceed the total amount of assessments payable at
48 a rate of five percent of the total premiums earned for
49 the previous calendar year. Reinsured carriers may
50 not resume writing small employer health benefit plans
51 on a guaranteed issue basis until the board of
52 directors determines that the expected loss will be
53 less than the maximum established by this subsection.

54 Revised Law

55 Sec. 1501.326. DEFERMENT OF ASSESSMENT. (a) A reinsured
56 health benefit plan issuer may petition the commissioner for a

1 deferment in whole or in part of an assessment imposed by the board.

2 (b) The commissioner may defer all or part of the assessment
3 if the commissioner determines that payment of the assessment would
4 endanger the ability of the reinsured health benefit plan issuer to
5 fulfill its contractual obligations.

6 (c) The board shall assess the amount of a deferred
7 assessment against other reinsured health benefit plan issuers in a
8 manner consistent with the basis for assessment established by this
9 subchapter.

10 (d) A reinsured health benefit plan issuer that receives a
11 deferment:

12 (1) is liable to the system for the amount deferred;
13 and

14 (2) until the issuer pays the outstanding assessment,
15 may not:

16 (A) market, deliver, or issue for delivery a
17 small employer health benefit plan; or

18 (B) reinsure any individual or group with the
19 system. (V.T.I.C. Art. 26.62.)

20 Source Law

21 Art. 26.62. (a) A reinsured carrier may
22 petition the commissioner for a deferment in whole or
23 in part of an assessment imposed by the board of
24 directors.

25 (b) The commissioner may defer all or part of
26 the assessment of a reinsured carrier if the
27 commissioner determines that the payment of the
28 assessment would endanger the ability of the reinsured
29 carrier to fulfill its contractual obligations.

30 (c) If an assessment against a reinsured carrier
31 is deferred, the amount deferred shall be assessed
32 against the other reinsured carriers in a manner
33 consistent with the basis for assessment established
34 by this subchapter.

35 (d) A reinsured carrier receiving a deferment is
36 liable to the system for the amount deferred and is
37 prohibited from marketing, delivering, or issuing for
38 delivery a small employer health benefit plan or
39 reinsuring any individual or group with the system
40 until it pays the outstanding assessment.

41 [Sections 1501.327-1501.350 reserved for expansion]

1 SUBCHAPTER H. MARKETING OF SMALL EMPLOYER HEALTH BENEFIT PLANS

2 Revised Law

3 Sec. 1501.351. MARKETING REQUIREMENTS. (a) Each small
4 employer health benefit plan issuer shall market a small employer
5 health benefit plan to eligible small employers in this state
6 through properly licensed agents.

7 (b) Each small employer purchasing a small employer health
8 benefit plan must be given a summary, in a format prescribed by the
9 commissioner, of the health benefit plans established by the
10 commissioner under Subchapter F.

11 (c) An agent shall offer and explain to a small employer on
12 inquiry and request by the employer each health benefit plan
13 established by the commissioner under Subchapter F. (V.T.I.C. Art.
14 26.71, Subsec. (a).)

15 Source Law

16 Art. 26.71. (a) Each small employer carrier
17 shall market the small employer health benefit plan
18 through properly licensed agents to eligible small
19 employers in this state. Each small employer
20 purchasing a small employer health benefit plan shall
21 be given a summary of the benefit plans established by
22 the commissioner under Subchapter E of this chapter.
23 The commissioner shall prescribe the format of the
24 summary. The agent shall offer and explain each of the
25 plans to the small employer on inquiry and request by
26 the small employer.

27 Revised Law

28 Sec. 1501.352. HEALTH STATUS AND CLAIMS EXPERIENCE;
29 PROHIBITED ACTS. (a) A small employer health benefit plan issuer
30 or agent may not, because of the health status or claims experience
31 of the eligible employees of a small employer and those employees'
32 dependents, directly or indirectly encourage or direct the employer
33 to:

34 (1) refrain from applying for coverage with the
35 issuer;

36 (2) seek coverage from another issuer; or

37 (3) apply for a particular small employer health
38 benefit plan.

39 (b) A small employer health benefit plan issuer may not

1 directly or indirectly enter into an agreement or arrangement with
2 an agent that provides for or results in compensation paid to the
3 agent for the sale of small employer health benefit plans that
4 varies because of health status or claims experience.

5 (c) Subsection (b) does not apply to an arrangement that
6 provides compensation to an agent based on a percentage of premium,
7 except that the percentage may not vary because of health status or
8 claims experience.

9 (d) A small employer health benefit plan issuer or agent may
10 not encourage a small employer to exclude an eligible employee from
11 health coverage provided in connection with the employee's
12 employment.

13 (e) A small employer health benefit plan issuer may not
14 terminate, fail to renew, or limit its contract or agreement of
15 representation with an agent for a reason related to the health
16 status or claims experience of a small employer group placed by the
17 agent with the issuer. (V.T.I.C. Art. 26.72; Art. 26.73, Subsec.
18 (b).)

19 Source Law

20 Art. 26.72. (a) A small employer carrier or
21 agent may not, directly or indirectly:

22 (1) encourage or direct a small employer
23 to refrain from applying for coverage with the small
24 employer carrier because of health status or claim
25 experience of the eligible employees and dependents of
26 the small employer;

27 (2) encourage or direct a small employer
28 to seek coverage from another health carrier because
29 of health status or claim experience of the eligible
30 employees and dependents of the small employer; or

31 (3) encourage or direct a small employer
32 to apply for a particular small employer health
33 benefit plan because of health status or claim
34 experience of the eligible employees and dependents of
35 the small employer.

36 (b) A small employer carrier may not, directly
37 or indirectly, enter into an agreement or arrangement
38 with an agent that provides for or results in the
39 compensation paid to an agent for the sale of the small
40 employer health benefit plans to be varied because of
41 health status or claim experience.

42 (c) Subsection (b) of this article does not
43 apply to an arrangement that provides compensation to
44 an agent on the basis of percentage of premium,
45 provided that the percentage may not vary because of
46 health status or claim experience.

47 (d) A small employer carrier or agent may not
48 encourage a small employer to exclude an eligible

1 employee from health coverage provided in connection
2 with the employee's employment.

3 [Art. 26.73]

4 (b) A small employer carrier may not terminate,
5 fail to renew, or limit its contract or agreement of
6 representation with an agent for any reason related to
7 the health status or claim experience of a small
8 employer group placed by the agent with the carrier.

9 Revised Law

10 Sec. 1501.353. AGENT COMPENSATION. (a) A small employer
11 health benefit plan issuer shall pay the same commission,
12 percentage of premium, or other amount to an agent for renewal of a
13 small employer health benefit plan as the issuer paid for original
14 placement of the plan, except that the issuer may increase
15 compensation for renewal of a plan to reflect an increase in the
16 cost of living or similar factors.

17 (b) A small employer health benefit plan issuer may not
18 implement, directly or indirectly, agent commission schedules that
19 vary the level of agent commissions based on the size of the group
20 or otherwise reduce access to small employer health benefit plans.

21 (c) Notwithstanding Subsection (b), a small employer health
22 benefit plan issuer may:

23 (1) vary agent commission amounts or percentages
24 based on group size if the variation in the commission amounts or
25 percentages are inversely related to the size of the group;

26 (2) vary agent commission amounts or percentages based
27 on the cumulative premium paid by a single small employer over a
28 specific period if the variation in the commission amounts or
29 percentages are inversely related to the cumulative premium paid
30 during the period; or

31 (3) pay agent commissions as a percentage of premiums
32 charged to a small employer if the commission percentage is based on
33 all premiums paid by the small employer. (V.T.I.C. Art. 26.73,
34 Subsecs. (a), (c), (d).)

35 Source Law

36 Art. 26.73. (a) A small employer carrier shall
37 pay the same commission, percentage of premium or
38 other amount to an agent for renewal of a small
39 employer health benefit plan as the carrier paid for

1 original placement of the plan. Compensation for
2 renewal of a plan may be adjusted upward to reflect an
3 increase in the cost of living or similar factors.

4 (c) A small employer carrier may not implement,
5 directly or indirectly, agent commission schedules
6 that vary the level of agent commissions based on the
7 size of the group, or otherwise reduce access to small
8 employer health benefit plans.

9 (d) Notwithstanding Subsection (c) of this
10 article, a small employer carrier may:

11 (1) vary agent commission amounts or
12 percentages based on group size if the variation in
13 the commission amounts or percentages are inversely
14 related to the size of the group;

15 (2) vary agent commission amounts or
16 percentages based on the cumulative premium paid by a
17 single small employer over a specific period if the
18 variation in the commission amounts or percentages are
19 inversely related to the cumulative premium paid
20 during the period; or

21 (3) pay agent commissions as a percentage
22 of premium charged to a small employer if the
23 commission percentage is based on all premium paid by
24 the small employer.

25 Revised Law

26 Sec. 1501.354. REQUIRED DISCLOSURES. (a) In connection
27 with offering a small employer health benefit plan for sale, each
28 small employer health benefit plan issuer and agent shall make a
29 reasonable disclosure, as part of its solicitation and sales
30 materials, of:

31 (1) the extent to which premium rates for a specific
32 small employer are established or adjusted based on the actual or
33 expected variation in:

34 (A) claim costs; or

35 (B) health status of the employer's employees and
36 their dependents;

37 (2) provisions concerning the issuer's right to change
38 premium rates and factors other than claims experience that affect
39 changes in premium rates;

40 (3) provisions relating to renewability of policies
41 and contracts; and

42 (4) any preexisting condition provisions.

43 (b) On request by a small employer, each small employer
44 health benefit plan issuer shall disclose the benefits and premiums
45 available under all small employer coverage for which the employer

1 is qualified.

2 (c) A small employer health benefit plan issuer is not
3 required to disclose information to a small employer that is
4 proprietary or trade secret information under applicable law.

5 (d) Information provided under this section to a small
6 employer must be provided in a manner that is:

7 (1) understandable by the average small employer; and

8 (2) sufficient to reasonably inform a small employer
9 of its rights and obligations under a small employer health benefit
10 plan. (V.T.I.C. Art. 26.40.)

11 Source Law

12 Art. 26.40. (a) In connection with the
13 offering for sale of any small employer health benefit
14 plan, each small employer carrier and each agent shall
15 make a reasonable disclosure, as part of its
16 solicitation and sales materials, of:

17 (1) the extent to which premium rates for a
18 specific small employer are established or adjusted
19 based on the actual or expected variation in claim
20 costs or the actual or expected variation in health
21 status of the employees of the small employer and their
22 dependents;

23 (2) provisions concerning the small
24 employer carrier's right to change premium rates and
25 the factors other than claim experience that affect
26 changes in premium rates;

27 (3) provisions relating to renewability of
28 policies and contracts; and

29 (4) any preexisting condition provision.

30 (b) Each small employer carrier shall disclose
31 on request by a small employer the benefits and
32 premiums available under all small employer coverage
33 for which the employer is qualified.

34 (c) A small employer carrier is not required to
35 disclose any information to a small employer that is
36 proprietary or trade secret information under
37 applicable law.

38 (d) Information provided under this article to
39 small employers must be provided in a manner that is
40 understandable by the average small employer and
41 sufficient to reasonably inform small employers of
42 their rights and obligations under a small employer
43 health benefit plan.

44 Revised Law

45 Sec. 1501.355. RULES CONCERNING MARKETING AND
46 AVAILABILITY. Rules adopted under Section 1501.010 may establish
47 additional standards to provide for the fair marketing and broad
48 availability of small employer health benefit plans to small
49 employers in this state. (V.T.I.C. Art. 26.75.)

1 Source Law

2 Art. 26.75. The commissioner may adopt rules
3 setting forth additional standards to provide for the
4 fair marketing and broad availability of small
5 employer health benefit plans to small employers in
6 this state.

7 Revisor's Note

8 V.T.I.C. Article 26.75 provides that the
9 commissioner of insurance "may adopt rules setting
10 forth additional standards to provide for the fair
11 marketing and broad availability of small employer
12 health benefit plans." The revised law omits the
13 portion of Article 26.75 authorizing the adoption of
14 rules and substitutes a reference to Section 1501.010
15 for the reason stated in Revisor's Note (2) to Section
16 1501.211.

17 Revised Law

18 Sec. 1501.356. REPORTING REQUIREMENTS. (a) In this
19 section, "case characteristics" has the meaning assigned by Section
20 1501.201.

21 (b) The department may require periodic reports by small
22 employer health benefit plan issuers and agents regarding small
23 employer health benefit plans issued by those issuers and agents.
24 The reporting requirements must include information regarding:

25 (1) case characteristics; and

26 (2) the number of small employer health benefit plans
27 in various categories that are marketed or issued to small
28 employers. (V.T.I.C. Art. 26.71, Subsec. (b).)

29 Source Law

30 (b) The department may require periodic reports
31 by small employer carriers and agents regarding small
32 employer health benefit plans issued by those carriers
33 and agents. The reporting requirements shall include
34 information regarding case characteristics and the
35 numbers of small employer health benefit plans in
36 various categories that are marketed or issued to
37 small employers.

38 Revised Law

39 Sec. 1501.357. VIOLATIONS. A violation of Section
40 1501.352 by a small employer health benefit plan issuer or agent is

1 an unfair method of competition and an unfair or deceptive act or
2 practice under Chapter 541. (V.T.I.C. Art. 26.76, Subsec. (a).)

3 Source Law

4 Art. 26.76. (a) A violation of Article 26.72
5 of this code by a small employer carrier or an agent is
6 an unfair method of competition and an unfair or
7 deceptive act or practice under Article 21.21 of this
8 code.

9 Revised Law

10 Sec. 1501.358. APPLICABILITY TO THIRD-PARTY ADMINISTRATOR.
11 If a small employer health benefit plan issuer enters into an
12 agreement with a third-party administrator to provide
13 administrative, marketing, or other services related to offering
14 small employer health benefit plans to small employers in this
15 state, the third-party administrator is subject to Sections
16 1501.111, 1501.351-1501.353, and 1501.355-1501.357. (V.T.I.C.
17 Art. 26.76, Subsec. (b).)

18 Source Law

19 (b) If a small employer carrier enters into an
20 agreement with a third-party administrator to provide
21 administrative, marketing, or other services related
22 to the offering of small employer health benefit plans
23 to small employers in this state, the third-party
24 administrator is subject to this subchapter.

25 [Subchapters I-L reserved for expansion]

26 SUBCHAPTER M. LARGE EMPLOYER HEALTH BENEFIT PLANS

27 Revised Law

28 Sec. 1501.601. PARTICIPATION CRITERIA. (a) In this
29 subchapter, "participation criteria" means any criteria or rules
30 established by a large employer to determine the employees who are
31 eligible for enrollment or continued enrollment under the terms of
32 a health benefit plan.

33 (b) The participation criteria may not be based on health
34 status related factors. (V.T.I.C. Art. 26.02, Subdiv. (20);
35 Art. 26.83, Subsec. (a) (part).)

36 Source Law

37 Art. 26.02. In this chapter:

38 (20) "Participation criteria" means any
39 criteria or rules established by a large employer to

1 determine the employees who are eligible for
2 enrollment, including continued enrollment, under the
3 terms of a health benefit plan. Such criteria or rules
4 may not be based on health status related factors.

5 Art. 26.83. (a) . . . The participation
6 criteria may not be based on health status related
7 factors.

8 Revised Law

9 Sec. 1501.602. COVERAGE REQUIREMENTS. (a) A large
10 employer health benefit plan issuer:

11 (1) may refuse to provide coverage to a large employer
12 in accordance with the issuer's underwriting standards and
13 criteria;

14 (2) shall accept or reject the entire group of
15 individuals who meet the participation criteria and choose
16 coverage; and

17 (3) may exclude only those employees or dependents who
18 decline coverage.

19 (b) On issuance of a health benefit plan to a large
20 employer, a large employer health benefit plan issuer shall provide
21 coverage to the employees who meet the participation criteria
22 without regard to an individual's health status related factors.

23 (V.T.I.C. Art. 26.83, Subsecs. (a) (part), (b) (part).)

24 Source Law

25 Art. 26.83. (a) A large employer carrier may
26 refuse to provide coverage to a large employer in
27 accordance with the carrier's underwriting standards
28 and criteria. However, on issuance of a health benefit
29 plan to a large employer, each large employer carrier
30 shall provide coverage to the employees who meet the
31 participation criteria established by the large
32 employer without regard to an individual's health
33 status related factors. . . .

34 (b) The large employer carrier shall accept or
35 reject the entire group of individuals who meet the
36 participation criteria established by the employer and
37 who choose coverage and may exclude only those
38 employees or dependents who have declined
39 coverage. . . .

40 Revisor's Note

41 Subsection (a), V.T.I.C. Article 26.83, requires
42 a large employer carrier to provide coverage under a
43 large employer health benefit plan to "the employees
44 who meet the participation criteria established by the

1 large employer." Subsection (b), V.T.I.C. Article
2 26.83, requires a large employer carrier to "accept or
3 reject the entire group of individuals who meet the
4 participation criteria established by the employer."
5 Throughout this subchapter, the revised law omits
6 references to the establishment of participation
7 criteria by an employer as unnecessary. Subdivision
8 (20), V.T.I.C. Article 26.02, revised as Section
9 1501.601, defines "participation criteria" to mean
10 "criteria or rules established by a large employer."

11 Revised Law

12 Sec. 1501.603. EXCLUSION OF ELIGIBLE EMPLOYEE OR DEPENDENT
13 PROHIBITED. A large employer health benefit plan issuer may not
14 exclude an employee who meets the participation criteria or an
15 eligible dependent, including a late enrollee, who would otherwise
16 be covered under a large employer group. (V.T.I.C. Art. 26.83,
17 Subsec. (1).)

18 Source Law

19 (1) A large employer carrier may not exclude any
20 employee who meets the participation criteria or an
21 eligible dependent, including a late enrollee, who
22 would otherwise be covered under a large employer
23 group.

24 Revised Law

25 Sec. 1501.604. DECLINING COVERAGE. (a) A large employer
26 health benefit plan issuer shall obtain a written waiver from each
27 employee who meets the participation criteria and declines coverage
28 under a health benefit plan offered to a large employer. The waiver
29 must ensure that the employee was not induced or pressured to
30 decline coverage because of the employee's health status related
31 factors.

32 (b) A large employer health benefit plan issuer may not
33 provide coverage to a large employer or the employer's employees if
34 the issuer or an agent for the issuer knows that the employer has
35 induced or pressured an employee who meets the participation
36 criteria or a dependent of the employee to decline coverage because

1 of the individual's health status related factors. (V.T.I.C. Art.
2 26.83, Subsecs. (c), (d).)

3 Source Law

4 (c) The large employer carrier shall obtain a
5 written waiver for each employee who meets the
6 participation criteria and who declines coverage under
7 the health plan offered to a large employer. The
8 waiver must ensure that the employee was not induced or
9 pressured into declining coverage because of the
10 employee's health status related factors.

11 (d) A large employer carrier may not provide
12 coverage to a large employer or the employees of a
13 large employer if the carrier or an agent for the
14 carrier knows that the large employer has induced or
15 pressured an employee who meets the participation
16 criteria or a dependent of the employee to decline
17 coverage because of that individual's health status
18 related factors.

19 Revised Law

20 Sec. 1501.605. MINIMUM CONTRIBUTION OR PARTICIPATION
21 REQUIREMENTS. (a) A large employer health benefit plan issuer
22 may require a large employer to meet a minimum contribution or
23 participation requirement as a condition of issuance or renewal in
24 accordance with the issuer's usual and customary practices for all
25 the issuer's employer health benefit plans in this state.

26 (b) A participation requirement may determine the
27 percentage of eligible employees who meet the participation
28 criteria and who must be enrolled in the health benefit plan.

29 (c) A large employer health benefit plan issuer may apply a
30 participation requirement to a large employer's eligible
31 employees, but may not apply the requirement to eligible dependents
32 of those employees.

33 (d) A participation requirement must be stated in the health
34 benefit plan contract and must be applied uniformly to each large
35 employer offered or issued coverage by a large employer health
36 benefit plan issuer in this state. (V.T.I.C. Art. 26.83, Subsec.
37 (e).)

38 Source Law

39 (e) A large employer carrier may require a large
40 employer to meet minimum contribution or participation
41 requirements as a condition of issuance and renewal in
42 accordance with the carrier's usual and customary
43 practices for all employer health benefit plans in

1 this state. The participation requirements may
2 determine the percentage of eligible employees who
3 meet the participation criteria established by the
4 employer who must be enrolled in the plan. A large
5 employer carrier may apply participation requirements
6 to the employer's eligible employees, but may not apply
7 those requirements to eligible dependents. Those
8 requirements must be stated in the contract and must be
9 applied uniformly to each large employer offered or
10 issued coverage by the large employer carrier in this
11 state.

12 Revised Law

13 Sec. 1501.606. EMPLOYEE ENROLLMENT; WAITING PERIOD. (a)

14 The initial enrollment period for employees meeting the
15 participation criteria under a large employer health benefit plan
16 must be at least 31 days, with a 31-day annual open enrollment
17 period.

18 (b) A large employer may establish a waiting period. The
19 employer shall determine the duration of the waiting period.

20 (c) A new employee who meets the participation criteria may
21 not be denied coverage if the application for coverage is received
22 by the large employer not later than the 31st day after the later
23 of:

24 (1) the date employment begins; or

25 (2) the date the waiting period established under
26 Subsection (b) expires.

27 (d) If dependent coverage is offered to the enrollees under
28 a large employer health benefit plan:

29 (1) the initial enrollment period for the dependents
30 must be at least 31 days, with a 31-day annual open enrollment
31 period; and

32 (2) a dependent of a new employee who meets the
33 participation criteria may not be denied coverage if the
34 application for coverage is received by the large employer not
35 later than the 31st day after the latest of:

36 (A) the date on which the employment begins;

37 (B) the date the waiting period established under
38 Subsection (b) expires; or

39 (C) the date the dependent becomes eligible for

1 enrollment.

2 (e) A late enrollee may be excluded from coverage until the
3 next annual open enrollment period and may be subject to a one-year
4 preexisting condition provision as described by Section 1501.102.
5 The period during which a preexisting condition provision applies
6 may not exceed 18 months from the date of the initial application.
7 (V.T.I.C. Art. 26.83, Subsecs. (f), (g), (h), (i), (j), (k).)

8 Source Law

9 (f) The initial enrollment period for employees
10 meeting the participation criteria must be at least 31
11 days, with a 31-day annual open enrollment period.

12 (g) If dependent coverage is offered to
13 enrollees under a large employer health benefit plan,
14 the initial enrollment period for the dependents must
15 be at least 31 days, with a 31-day annual open
16 enrollment period.

17 (h) A large employer may establish a waiting
18 period during which a new employee is not eligible for
19 coverage. The employer shall determine the duration
20 of the waiting period.

21 (i) A new employee who meets the participation
22 criteria of a covered large employer may not be denied
23 coverage if the application for coverage is received
24 by the large employer not later than the 31st day after
25 the later of:

26 (1) the date on which the employment
27 begins; or

28 (2) the date on which the waiting period
29 established under Subsection (h) of this article
30 expires.

31 (j) If dependent coverage is offered to the
32 enrollees under a large employer health benefit plan,
33 a dependent of a new employee who meets the
34 participation criteria established by the large
35 employer may not be denied coverage if the application
36 for coverage is received by the large employer not
37 later than the 31st day after the later of:

38 (1) the date on which the employment
39 begins;

40 (2) the date on which the waiting period
41 established under Subsection (h) of this article
42 expires; or

43 (3) the date on which the dependent
44 becomes eligible for enrollment.

45 (k) A late enrollee may be excluded from
46 coverage until the next annual open enrollment period
47 and may be subject to a 12-month preexisting condition
48 provision as described by Article 26.90 of this code.
49 The period during which a preexisting condition
50 provision applies may not exceed 18 months from the
51 date of the initial application.

52 Revisor's Note

53 Subsection (h), V.T.I.C. Article 26.83, provides
54 that a large employer may establish a waiting period
55 "during which a new employee is not eligible for

1 coverage." The revised law omits the quoted language
2 for the reason stated in the revisor's note to Section
3 1501.156.

4 Revised Law

5 Sec. 1501.607. COVERAGE FOR NEWBORN CHILDREN. (a) A
6 large employer health benefit plan may not limit or exclude initial
7 coverage of a newborn child of a covered employee.

8 (b) Coverage of a newborn child of a covered employee under
9 this section ends on the 32nd day after the date of the child's
10 birth unless:

11 (1) children are eligible for coverage under the large
12 employer health benefit plan; and

13 (2) not later than the 31st day after the date of
14 birth, the large employer health benefit plan issuer receives:

15 (A) notice of the birth; and

16 (B) any required additional premium. (V.T.I.C.
17 Art. 26.84, Subsec. (a).)

18 Source Law

19 Art. 26.84. (a) A large employer health
20 benefit plan may not limit or exclude initial coverage
21 of a newborn child of a covered employee. Any coverage
22 of a newborn child of a covered employee under this
23 subsection terminates on the 32nd day after the date of
24 the birth of the child unless:

25 (1) children are eligible for coverage
26 under the large employer health benefit plan; and

27 (2) notification of the birth and any
28 required additional premium are received by the large
29 employer carrier not later than the 31st day after the
30 date of birth.

31 Revised Law

32 Sec. 1501.608. COVERAGE FOR ADOPTED CHILDREN. (a) This
33 section applies only if children are eligible for coverage under a
34 large employer health benefit plan.

35 (b) A large employer health benefit plan may not limit or
36 exclude initial coverage of an adopted child of an insured. A child
37 is considered to be the adopted child of an insured if the insured
38 is a party to a suit in which the insured seeks to adopt the child.

39 (c) An adopted child of an insured may be enrolled, at the

1 insured's option, not later than the 31st day after:

2 (1) the date the insured becomes a party to a suit in
3 which the insured seeks to adopt the child; or

4 (2) the date the adoption becomes final.

5 (d) Coverage of an adopted child of an insured under this
6 section ends unless the large employer health benefit plan issuer
7 receives notice of the adoption and any required additional premium
8 not later than the 31st day after:

9 (1) the date the insured becomes a party to a suit in
10 which the insured seeks to adopt the child; or

11 (2) the date the adoption becomes final. (V.T.I.C.
12 Art. 26.84, Subsecs. (b), (c), (d).)

13 Source Law

14 (b) If children are eligible for coverage under
15 the large employer health benefit plan, a large
16 employer health benefit plan may not limit or exclude
17 initial coverage of an adopted child of an insured. A
18 child is considered to be the child of an insured if
19 the insured is a party in a suit in which the adoption
20 of the child by the insured is sought.

21 (c) If children are eligible for coverage under
22 the large employer health benefit plan an adopted
23 child of an insured may be enrolled, at the option of
24 the insured, within either:

25 (1) 31 days after the insured is a party in
26 a suit for adoption; or

27 (2) 31 days of the date the adoption is
28 final.

29 (d) Coverage of an adopted child of an employee
30 under this article terminates unless notification of
31 the adoption and any required additional premiums are
32 received by the large employer carrier not later than
33 either:

34 (1) the 31st day after the insured becomes
35 a party in a suit in which the adoption of the child by
36 the insured is sought; or

37 (2) the 31st day after the date of the
38 adoption.

39 Revised Law

40 Sec. 1501.609. COVERAGE FOR UNMARRIED CHILDREN. (a) This
41 section applies only if children are eligible for coverage under a
42 large employer health benefit plan.

43 (b) Any limiting age applicable under a large employer
44 health benefit plan to an unmarried child of an enrollee is 25 years
45 of age. (V.T.I.C. Art. 26.84, Subsec. (e).)

1 Source Law

2 (e) If children are eligible for coverage under
3 the terms of a large employer health benefit plan, any
4 limiting age applicable to an unmarried child of an
5 enrollee is 25 years of age.

6 Revised Law

7 Sec. 1501.610. PREMIUM RATES; ADJUSTMENTS. (a) A large
8 employer health benefit plan issuer may charge premiums in
9 accordance with this section to the group of employees or
10 dependents who meet the participation criteria and do not decline
11 coverage.

12 (b) A large employer health benefit plan issuer may not
13 charge an adjustment to premium rates for individual employees or
14 dependents for health status related factors or duration of
15 coverage. Any adjustment must be applied uniformly to the rates
16 charged for all employees and dependents of employees of a large
17 employer.

18 (c) Subsection (b) does not restrict the amount that a large
19 employer may be charged for coverage. (V.T.I.C. Art. 26.83,
20 Subsec. (b) (part); Art. 26.89, Subsec. (a).)

21 Source Law

22 [Art. 26.83]

23 (b) . . . The carrier may charge premiums in
24 accordance with Article 26.89 of this code to the group
25 of employees or dependents who meet the participation
26 criteria established by the employer and who do not
27 decline coverage.

28 Art. 26.89. (a) A large employer carrier may
29 not charge an adjustment to premium rates for
30 individual employees or dependents for health status
31 related factors or duration of coverage. Any
32 adjustment must be applied uniformly to the rates
33 charged for all employees and dependents of employees
34 of the large employer. This subsection does not
35 restrict the amount that a large employer may be
36 charged for coverage.

37 Revised Law

38 Sec. 1501.611. MARKETING REQUIREMENTS. On request, each
39 large employer purchasing a health benefit plan shall be given a
40 summary of all plans for which the employer is eligible. (V.T.I.C.
41 Art. 26.91, Subsec. (a).)

1 Source Law

2 Art. 26.91. (a) On request, each large
3 employer purchasing health benefit plans shall be
4 given a summary of all plans for which the employer is
5 eligible.

6 Revised Law

7 Sec. 1501.612. ENCOURAGING EXCLUSION OF EMPLOYEE
8 PROHIBITED. A large employer health benefit plan issuer or agent
9 may not encourage a large employer to exclude an employee who meets
10 the participation criteria from health coverage provided in
11 connection with the employee's employment. (V.T.I.C. Art. 26.92.)

12 Source Law

13 Art. 26.92. A large employer carrier or agent
14 may not encourage a large employer to exclude an
15 employee, meeting the participation criteria, from
16 health coverage provided in connection with the
17 employee's employment.

18 Revised Law

19 Sec. 1501.613. AGENTS. A large employer health benefit
20 plan issuer may not terminate, fail to renew, or limit its contract
21 or agreement of representation with an agent because of health
22 status related factors of a large employer group placed by the agent
23 with the issuer. (V.T.I.C. Art. 26.93.)

24 Source Law

25 Art. 26.93. A large employer carrier may not
26 terminate, fail to renew, or limit its contract or
27 agreement of representation with an agent because of
28 any health status related factors of a large employer
29 group placed by the agent with the carrier.

30 Revised Law

31 Sec. 1501.614. REPORTING OF CLAIMS INFORMATION. (a) This
32 section applies only to an insured employer health benefit plan.

33 (b) An employer carrier, on written request from an insured
34 employer covered by that carrier, shall report to the employer
35 information from the 12 months preceding the date of the report
36 regarding:

37 (1) the total amount of charges submitted to the
38 carrier for persons covered under the employer health benefit plan;

39 (2) the total amount of payments made by the carrier to
40 health care providers for persons covered under the plan; and

1 (3) to the extent available, information on claims
2 paid by type of health care provider, including total hospital
3 charges, physician charges, pharmaceutical charges, and other
4 charges.

5 (c) An employer carrier shall provide information requested
6 by an employer under this section annually not later than the 30th
7 day before the anniversary or renewal date of the employer's health
8 benefit plan.

9 (d) Notwithstanding Subsection (c), an employer carrier is
10 not required to provide information under Subsection (b) earlier
11 than the 30th day after the date of the initial written request.

12 (e) An employer carrier may not report any information
13 required under this section if the release of the information is
14 prohibited by federal law or regulation.

15 (f) An employer carrier shall provide claim information
16 under this section in the aggregate, without information through
17 which a specific individual covered by the health insurance or
18 evidence of coverage may be identified. (V.T.I.C. Art. 26.96.)

19 Source Law

20 Art. 26.96. (a) This article applies only to
21 an insured employer health benefit plan.

22 (b) An employer carrier, on written request from
23 an insured employer covered by that carrier, shall
24 report to the employer information from the 12 months
25 preceding the date of the report regarding:

26 (1) the total amount of charges submitted
27 to the carrier for persons covered under the employer
28 health benefit plan;

29 (2) the total amount of payments made by
30 the carrier to health care providers for persons
31 covered under the plan; and

32 (3) to the extent available, information
33 on claims paid by type of health care provider,
34 including the total hospital charges, physician
35 charges, pharmaceutical charges, and other charges.

36 (c) An employer carrier shall provide
37 information requested by an employer under this
38 article annually not later than the 30th day before the
39 anniversary or renewal date of the employer's health
40 benefit plan.

41 (d) Notwithstanding Subsection (c) of this
42 article, an employer is not required to provide
43 information under Subsection (b) of this article
44 earlier than the 30th day after the date of the initial
45 written request.

46 (e) An employer carrier may not report any
47 information required under this article the release of
48 which is prohibited by federal law or regulation.

1 (f) Claim information provided by an employer
2 carrier under this section shall be provided in the
3 aggregate, without information through which a
4 specific individual covered by the health insurance or
5 evidence of coverage may be identified.

6 Revised Law

7 Sec. 1501.615. ADDITIONAL REPORTING REQUIREMENTS. The
8 department may require periodic reports by large employer health
9 benefit plan issuers and agents regarding the large employer health
10 benefit plans issued by those issuers. The reporting requirements
11 must:

12 (1) require information regarding the number of plans
13 in various categories that are marketed or issued to large
14 employers; and

15 (2) comply with federal law, including regulations.
16 (V.T.I.C. Art. 26.91, Subsec. (b).)

17 Source Law

18 (b) The department may require periodic reports
19 by large employer carriers and agents regarding the
20 large employer health benefit plans issued by those
21 carriers. The reporting requirements must require
22 information regarding the number of large employer
23 health benefit plans in various categories that are
24 marketed or issued to large employers and must comply
25 with federal law and regulations.

26 Revised Law

27 Sec. 1501.616. APPLICABILITY TO THIRD-PARTY ADMINISTRATOR.
28 If a large employer health benefit plan issuer enters into an
29 agreement with a third-party administrator to provide
30 administrative, marketing, or other services related to offering
31 large employer health benefit plans to large employers in this
32 state, the third-party administrator is subject to this subchapter
33 and Subchapter C. (V.T.I.C. Art. 26.95.)

34 Source Law

35 Art. 26.95. If a large employer carrier enters
36 into an agreement with a third-party administrator to
37 provide administrative, marketing, or other services
38 related to the offering of large employer health
39 benefit plans to large employers in this state, the
40 third-party administrator is subject to this
41 subchapter.

42 CHAPTER 1502. HEALTH BENEFIT PLANS FOR CHILDREN

43 SUBCHAPTER A. GENERAL PROVISIONS

1 Sec. 1502.001. APPLICABILITY OF CHAPTER 1271
2 Sec. 1502.002. RULES 1273
3 [Sections 1502.003-1502.050 reserved for expansion]
4 SUBCHAPTER B. CHILDREN'S HEALTH BENEFIT PLAN
5 Sec. 1502.051. CHILDREN'S HEALTH BENEFIT PLAN 1274
6 Sec. 1502.052. MANDATED BENEFIT PROVISIONS INAPPLICABLE. . . 1274
7 Sec. 1502.053. EXEMPTION FROM CERTAIN TAXES 1274

8 CHAPTER 1502. HEALTH BENEFIT PLANS FOR CHILDREN

9 SUBCHAPTER A. GENERAL PROVISIONS

10 Revised Law

11 Sec. 1502.001. APPLICABILITY OF CHAPTER. This chapter
12 applies only to the issuer of a health benefit plan that:

13 (1) provides benefits for medical or surgical expenses
14 incurred as a result of a health condition, accident, or sickness,
15 including:

16 (A) an individual, group, blanket, or franchise
17 insurance policy or insurance agreement, a group hospital service
18 contract, or an individual or group evidence of coverage that is
19 offered by:

- 20 (i) an insurance company;
- 21 (ii) a group hospital service corporation
22 operating under Chapter 842;
- 23 (iii) a fraternal benefit society operating
24 under Chapter 885;
- 25 (iv) a stipulated premium company operating
26 under Chapter 884; or
- 27 (v) a health maintenance organization
28 operating under Chapter 843; and

29 (B) to the extent permitted by the Employee
30 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et
31 seq.), a health benefit plan that is offered by:

- 32 (i) a multiple employer welfare arrangement
33 as defined by Section 3 of that Act or another analogous benefit
34 arrangement; or

1 (ii) an entity not authorized under this
2 code or another insurance law of this state that contracts directly
3 for health care services on a risk-sharing basis, including a
4 capitation basis; or

5 (2) is offered by an approved nonprofit health
6 corporation that holds a certificate of authority under Chapter
7 844. (V.T.I.C. Art. 27.02.)

8 Source Law

9 Art. 27.02. This chapter applies to a health
10 benefit plan that:

11 (1) provides benefits for medical or
12 surgical expenses incurred as a result of a health
13 condition, accident, or sickness, including:

14 (A) an individual, group, blanket, or
15 franchise insurance policy or insurance agreement, a
16 group hospital service contract, or an individual or
17 group evidence of coverage that is offered by:

18 (i) an insurance company;
19 (ii) a group hospital service
20 corporation operating under Chapter 20 of this code;
21 (iii) a fraternal benefit
22 society operating under Chapter 10 of this code;
23 (iv) a stipulated premium
24 insurance company operating under Chapter 22 of this
25 code; or

26 (v) a health maintenance
27 organization operating under the Texas Health
28 Maintenance Organization Act (Chapter 20A, Vernon's
29 Texas Insurance Code); or

30 (B) to the extent permitted by the
31 Employee Retirement Income Security Act of 1974 (29
32 U.S.C. Section 1001 et seq.), a health benefit plan
33 that is offered by:

34 (i) a multiple employer welfare
35 arrangement as defined by Section 3, Employee
36 Retirement Income Security Act of 1974 (29 U.S.C.
37 Section 1002) or another analogous benefit
38 arrangement; or

39 (ii) any other entity not
40 licensed under this code or another insurance law of
41 this state that contracts directly for health care
42 services on a risk sharing basis, including an entity
43 that contracts for health care services on a
44 capitation basis; or

45 (2) is offered by an approved nonprofit
46 health corporation that is certified under Section
47 5.01(a), Medical Practice Act (Article 4495b, Vernon's
48 Texas Civil Statutes), and that holds a certificate of
49 authority issued by the commissioner under Article
50 21.52F of this code.

51 Revisor's Note

52 (1) V.T.I.C. Article 27.02(1)(B)(ii) refers to
53 a health benefit plan offered by an entity that is not
54 "licensed" under the Insurance Code or another

1 insurance law of this state. The revised law
2 substitutes "authorized" for "licensed" for
3 consistency with terminology used throughout this
4 code.

5 (2) V.T.I.C. Article 27.02(2) refers to an
6 approved nonprofit health corporation that is
7 "certified under Section 5.01(a), Medical Practice
8 Act," and holds a certificate of authority "issued by
9 the commissioner under Article 21.52F." The revised
10 law omits the reference to certification under Section
11 5.01(a), Medical Practice Act (Article 4495b, Vernon's
12 Texas Civil Statutes), which was codified in 1999 in
13 Chapter 162, Occupations Code, as unnecessary because
14 V.T.I.C. Article 21.52F, revised as Chapter 844 of
15 this code, requires a nonprofit corporation to be
16 certified under that provision as a condition of
17 holding a certificate of authority. The revised law
18 also omits the reference to the commissioner issuing
19 the certificate of authority as unnecessary because
20 Chapter 844 requires the commissioner to issue the
21 certificate of authority.

22 (3) V.T.I.C. Article 27.01 defines "health
23 benefit plan." The revised law omits the definition as
24 unnecessary because V.T.I.C. Article 27.02, revised as
25 Section 1502.001, specifies the types of health
26 benefit plans that may be issued by a health benefit
27 plan issuer to which the chapter applies, and thus the
28 defined term is not helpful to the reader. The omitted
29 law reads:

30 Art. 27.01. In this chapter, "health
31 benefit plan" means a health benefit plan
32 described by Article 27.02 of this code.

33 Revised Law

34 Sec. 1502.002. RULES. The commissioner may adopt rules to
35 implement this chapter. (V.T.I.C. Art. 27.06.)

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Source Law

Art. 27.06. The commissioner may adopt rules to implement this chapter.

[Sections 1502.003-1502.050 reserved for expansion]

SUBCHAPTER B. CHILDREN'S HEALTH BENEFIT PLAN

Revised Law

Sec. 1502.051. CHILDREN'S HEALTH BENEFIT PLAN. A health benefit plan issuer may offer a children's health benefit plan that provides coverage only to children younger than 18 years of age. The issuer may offer the plan only if the commissioner approves the plan's structure and the benefits offered under the plan. (V.T.I.C. Art. 27.03.)

Source Law

Art. 27.03. (a) The issuer of a health benefit plan may offer a children's health benefit plan in accordance with this chapter. The health benefit plan may provide coverage only to children younger than 18 years of age.

(b) An issuer of a health benefit plan may not offer a children's health benefit plan under this chapter unless the plan's structure and the benefits offered under the plan have been approved by the commissioner.

Revised Law

Sec. 1502.052. MANDATED BENEFIT PROVISIONS INAPPLICABLE. A children's health benefit plan is not subject to any law that requires coverage or the offer of coverage of a health care service or benefit. (V.T.I.C. Art. 27.04.)

Source Law

Art. 27.04. A children's health benefit plan is not subject to a law that requires coverage or the offer of coverage of a health care service or benefit.

Revised Law

Sec. 1502.053. EXEMPTION FROM CERTAIN TAXES. A children's health benefit plan issuer is not subject to the premium tax or the tax on revenues imposed under Chapter 222 with respect to money received for coverage provided under that plan. (V.T.I.C. Art. 27.05.)

Source Law

Art. 27.05. The issuer of a children's health

1 benefit plan is not subject to the premium tax imposed
2 by Article 4.11 of this code or the tax on revenues
3 imposed under Section 33, Texas Health Maintenance
4 Organization Act (Article 20A.33, Vernon's Texas
5 Insurance Code), with respect to money received for
6 coverage provided under that plan.

7 CHAPTER 1503. COVERAGE OF CERTAIN STUDENTS

8 Sec. 1503.001. APPLICABILITY OF CHAPTER 1275
9 Sec. 1503.002. EXCEPTION. 1277
10 Sec. 1503.003. COVERAGE OF CERTAIN STUDENTS 1278

11 CHAPTER 1503. COVERAGE OF CERTAIN STUDENTS

12 Revised Law

13 Sec. 1503.001. APPLICABILITY OF CHAPTER. This chapter
14 applies only to a health benefit plan that:

15 (1) provides benefits for medical or surgical expenses
16 incurred as a result of a health condition, accident, or sickness,
17 including:

18 (A) an individual, group, blanket, or franchise
19 insurance policy or insurance agreement, a group hospital service
20 contract, or an individual or group evidence of coverage that is
21 offered by:

22 (i) an insurance company;

23 (ii) a group hospital service corporation
24 operating under Chapter 842;

25 (iii) a fraternal benefit society operating
26 under Chapter 885;

27 (iv) a stipulated premium company operating
28 under Chapter 884; or

29 (v) a health maintenance organization
30 operating under Chapter 843; and

31 (B) to the extent permitted by the Employee
32 Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et
33 seq.), a health benefit plan that is offered by:

34 (i) a multiple employer welfare arrangement
35 as defined by Section 3 of that Act; or

36 (ii) an analogous benefit arrangement; or

37 (2) is offered by:

1 (A) an approved nonprofit health corporation
2 that holds a certificate of authority under Chapter 844; or

3 (B) another entity that:

4 (i) is not authorized under this code or
5 another insurance law of this state; and

6 (ii) contracts directly for health care
7 services on a risk-sharing basis, including a capitation basis.

8 (V.T.I.C. Art. 21.24-2, Sec. 2(a).)

9 Source Law

10 [Sec. 1. In this article, "health benefit plan"
11 means a plan described by Section 2 of this article.]

12 Sec. 2. (a) This article applies to a health
13 benefit plan that:

14 (1) provides benefits for medical or
15 surgical expenses incurred as a result of a health
16 condition, accident, or sickness, including:

17 (A) an individual, group, blanket, or
18 franchise insurance policy or insurance agreement, a
19 group hospital service contract, or an individual or
20 group evidence of coverage that is offered by:

21 (i) an insurance company;

22 (ii) a group hospital service
23 corporation operating under Chapter 20 of this code;

24 (iii) a fraternal benefit
25 society operating under Chapter 10 of this code;

26 (iv) a stipulated premium
27 insurance company operating under Chapter 22 of this
28 code; or

29 (v) a health maintenance
30 organization operating under the Texas Health
31 Maintenance Organization Act (Chapter 20A, Vernon's
32 Texas Insurance Code); or

33 (B) to the extent permitted by the
34 Employee Retirement Income Security Act of 1974 (29
35 U.S.C. Section 1001 et seq.), a health benefit plan
36 that is offered by:

37 (i) a multiple employer welfare
38 arrangement as defined by Section 3, Employee
39 Retirement Income Security Act of 1974 (29 U.S.C.
40 Section 1002); or

41 (ii) another analogous benefit
42 arrangement;

43 (2) is offered by an approved nonprofit
44 health corporation that is certified under Section
45 162.001, Occupations Code, and that holds a
46 certificate of authority issued by the commissioner
47 under Article 21.52F of this code; or

48 (3) is offered by any other entity not
49 licensed under this code or another insurance law of
50 this state that contracts directly for health care
51 services on a risk-sharing basis, including an entity
52 that contracts for health care services on a
53 capitation basis.

54 Revisor's Note

55 (1) Section 2(a)(2), V.T.I.C. Article 21.24-2,

1 refers to an approved nonprofit health corporation
2 that is "certified under Section 162.001, Occupations
3 Code," and holds a certificate of authority "issued by
4 the commissioner under Article 21.52F." The revised
5 law omits the reference to certification under Section
6 162.001, Occupations Code, as unnecessary because
7 V.T.I.C. Article 21.52F, revised as Chapter 844 of
8 this code, requires a nonprofit corporation to be
9 certified under Section 162.001, Occupations Code, as
10 a condition of holding a certificate of authority. The
11 revised law also omits as unnecessary the reference to
12 the commissioner's issuing the certificate of
13 authority because Chapter 844 requires the
14 commissioner to issue the certificate of authority.

15 (2) Section 2(a)(3), V.T.I.C. Article 21.24-2,
16 refers to a health benefit plan offered by an entity
17 not "licensed" under this code or another insurance
18 law of this state. The revised law substitutes
19 "authorized" for "licensed" for consistency with
20 terminology used throughout this code.

21 Revised Law

22 Sec. 1503.002. EXCEPTION. This chapter does not apply to:

- 23 (1) a plan that provides coverage:
- 24 (A) only for a specified disease;
 - 25 (B) only for accidental death or dismemberment;
 - 26 (C) for wages or payments in lieu of wages for a
27 period during which an employee is absent from work because of
28 sickness or injury; or
 - 29 (D) as a supplement to a liability insurance
30 policy;
- 31 (2) a small employer health benefit plan written under
32 Chapter 1501;
- 33 (3) a Medicare supplemental policy as defined by
34 Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss),

1 as amended;

2 (4) a workers' compensation insurance policy;

3 (5) medical payment insurance coverage provided under
4 a motor vehicle insurance policy; or

5 (6) a long-term care insurance policy, including a
6 nursing home fixed indemnity policy, unless the commissioner
7 determines that the policy provides benefit coverage so
8 comprehensive that the policy is a health benefit plan as described
9 by Section 1503.001. (V.T.I.C. Art. 21.24-2, Sec. 2(b).)

10 Source Law

11 [Sec. 1. In this article, "health benefit plan"
12 means a plan described by Section 2 of this article.]

13 [Sec. 2]

14 (b) This article does not apply to:

15 (1) a plan that provides coverage:

16 (A) only for a specified disease;

17 (B) only for accidental death or
18 dismemberment;

19 (C) for wages or payments in lieu of
20 wages for a period during which an employee is absent
21 from work because of sickness or injury; or

22 (D) as a supplement to liability
23 insurance;

24 (2) a small employer health benefit plan
25 written under Chapter 26 of this code;

26 (3) a Medicare supplemental policy as
27 defined by Section 1882(g)(1), Social Security Act (42
28 U.S.C. Section 1395ss);

29 (4) workers' compensation insurance
30 coverage;

31 (5) medical payment insurance issued as
32 part of a motor vehicle insurance policy; or

33 (6) a long-term care policy, including a
34 nursing home fixed indemnity policy, unless the
35 commissioner determines that the policy provides
36 benefit coverage so comprehensive that the policy is a
37 health benefit plan as described by Subsection (a) of
38 this section.

39 Revised Law

40 Sec. 1503.003. COVERAGE OF CERTAIN STUDENTS. (a) A
41 health benefit plan may not condition coverage for a child younger
42 than 25 years of age on the child's being enrolled at an educational
43 institution.

44 (b) A health benefit plan that requires as a condition of
45 coverage for a child up to 25 years of age that the child be a
46 full-time student at an educational institution must provide the
47 coverage:

1 (1) for the entire academic term during which the
2 child begins as a full-time student and remains enrolled,
3 regardless of whether the number of hours of instruction for which
4 the child is enrolled is reduced to a level that changes the child's
5 academic status to less than that of a full-time student; and

6 (2) continuously until the 10th day of instruction of
7 the subsequent academic term, on which date the health benefit plan
8 may terminate coverage for the child if the child does not return to
9 full-time student status before that date.

10 (c) For purposes of this section, determination of the
11 full-time student status of a child is made in the manner provided
12 by the educational institution at which the child is enrolled.
13 (V.T.I.C. Art. 21.24-2, Sec. 3.)

14 Source Law

15 Sec. 3. (a) Each health benefit plan that
16 conditions coverage for a child up to 25 years of age
17 on the child's being a full-time student at an
18 educational institution shall provide the coverage for
19 an entire academic term during which the child begins
20 as a full-time student and remains enrolled,
21 regardless of whether the number of hours of
22 instruction for which the child is enrolled is reduced
23 to a level that changes the child's academic status to
24 less than that of a full-time student. Additionally,
25 the health benefit plan shall provide the coverage
26 continuously until the 10th day of instruction of the
27 subsequent academic term on which date the health
28 benefit plan may terminate coverage of the child if the
29 child does not return to full-time student status
30 before that date. A health benefit plan may not
31 condition coverage for a child younger than 25 years of
32 age on the child's being enrolled at an educational
33 institution.

34 (b) For purposes of this section, determination
35 of the full-time student status of a child subject to
36 this article is made in the manner provided by the
37 educational institution at which the child is
38 enrolled.

39 Revisor's Note
40 (End of Chapter)

41 Section 1, V.T.I.C. Article 21.24-2, defines
42 "health benefit plan." The revised law omits the
43 definition as unnecessary because Section 2 of that
44 article, revised as Sections 1503.001 and 1503.002,
45 specifies the types of health benefit plans to which
46 this chapter applies, and thus the defined term is not

1 helpful to the reader. The omitted law reads:

2 Art. 21.24-2
3 Sec. 1. In this article, "health
4 benefit plan" means a plan described by
5 Section 2 of this article.

6 CHAPTER 1504. MEDICAL CHILD SUPPORT

7 SUBCHAPTER A. GENERAL PROVISIONS

8 Sec. 1504.001. DEFINITIONS 1280

9 Sec. 1504.002. RULES 1282

10 Sec. 1504.003. VIOLATION OF CHAPTER: RELIEF AVAILABLE
11 TO INJURED PERSON 1283

12 [Sections 1504.004-1504.050 reserved for expansion]

13 SUBCHAPTER B. DUTIES OF HEALTH BENEFIT PLAN ISSUER

14 Sec. 1504.051. ENROLLMENT OF CERTAIN CHILDREN REQUIRED . . . 1284

15 Sec. 1504.052. CHILD RESIDING OUTSIDE SERVICE AREA;
16 COMPARABLE HEALTH COVERAGE REQUIRED 1284

17 Sec. 1504.053. CANCELLATION OR NONRENEWAL OF COVERAGE
18 FOR CERTAIN CHILDREN 1286

19 Sec. 1504.054. CONTINUATION OR CONVERSION OF COVERAGE 1286

20 Sec. 1504.055. PROCEDURE FOR CLAIMS 1287
21 [Sections 1504.056-1504.100 reserved for expansion]

22 SUBCHAPTER C. PROHIBITED CONDUCT

23 Sec. 1504.101. DENIAL OF ENROLLMENT ON CERTAIN GROUNDS
24 PROHIBITED 1289

25 Sec. 1504.102. ASSIGNMENT OF MEDICAL SUPPORT RIGHTS:
26 DIFFERENT REQUIREMENTS PROHIBITED 1290

27 CHAPTER 1504. MEDICAL CHILD SUPPORT

28 SUBCHAPTER A. GENERAL PROVISIONS

29 Revised Law

30 Sec. 1504.001. DEFINITIONS. In this chapter:

31 (1) "Child" has the meaning assigned by Section
32 101.003, Family Code.

33 (2) "Child support agency" has the meaning assigned by
34 Section 101.004, Family Code.

35 (3) "Custodial parent" means an individual who:

1 (A) is a managing conservator of a child or a
2 possessory conservator of a child who is a parent of the child; or

3 (B) is a guardian of the person or other
4 custodian of a child and is designated as guardian or custodian by a
5 court or administrative agency of this or another state.

6 (4) "Health benefit plan issuer" means:

7 (A) an insurance company, group hospital service
8 corporation, or health maintenance organization that delivers or
9 issues for delivery an individual, group, blanket, or franchise
10 insurance policy or agreement, a group hospital service contract,
11 or an evidence of coverage that provides benefits for medical or
12 surgical expenses incurred as a result of an accident or sickness;

13 (B) a governmental entity subject to Subchapter
14 D, Chapter 1355, Subchapter C, Chapter 1364, Chapter 1578, or
15 Article 3.51-1, 3.51-2, 3.51-4, or 3.51-5;

16 (C) the issuer of a multiple employer welfare
17 arrangement as defined by Section 846.001; or

18 (D) the issuer of a group health plan as defined
19 by Section 607, Employee Retirement Income Security Act of 1974 (29
20 U.S.C. Section 1167).

21 (5) "Medical assistance" means medical assistance
22 under the state Medicaid program. (V.T.I.C. Art. 3.96-1.)

23 Source Law

24 Art. 3.96-1. In this subchapter:

25 (1) "Child" has the meaning assigned by
26 Subsections (a) and (b), Section 101.003, Family Code.

27 (2) "Child support agency" has the meaning
28 assigned by Section 101.004, Family Code.

29 (3) "Custodial parent" means:

30 (A) a managing conservator of a child
31 or a possessory conservator of a child who is a parent
32 of the child; or

33 (B) a guardian of the person of a
34 child, or another custodian of a child if the guardian
35 or custodian is designated by a court or
36 administrative agency of this or another state.

37 (4) "Health insurer" means any insurance
38 company, group hospital service corporation, or health
39 maintenance organization that delivers or issues for
40 delivery an individual, group, blanket, or franchise
41 insurance policy or insurance agreement, a group
42 hospital service contract, or an evidence of coverage
43 that provides benefits for medical or surgical
44 expenses incurred as a result of an accident or

1 sickness.

2 (5) "Insurer" means:

3 (A) a health insurer;

4 (B) a governmental entity subject to:

5 (i) Article 3.51-1, 3.51-2,
6 3.51-4, 3.51-5, or 3.51-5A of this code; or

7 (ii) Section 1, Chapter 123,
8 Acts of the 60th Legislature, Regular Session, 1967
9 (Article 3.51-3, Vernon's Texas Insurance Code);

10 (C) a multiple employer welfare
11 arrangement, as that term is defined by Article 3.95-1
12 of this code; or

13 (D) a group health plan, as defined
14 by Section 607(1), Employee Retirement Income Security
15 Act of 1974 (29 U.S.C. Section 1167).

16 (6) "Medical assistance" means medical
17 assistance under the state Medicaid program.

18 Revisor's Note

19 Subdivision (5), V.T.I.C. Article 3.96-1,
20 defines "insurer" to include the defined term "health
21 insurer." "Health insurer" is a term used in
22 conjunction with traditional health insurance.
23 Included in the definition of "health insurer" are
24 entities such as health maintenance organizations,
25 which are not traditional insurers. Consequently,
26 "health benefit plan issuer" is a more accurate term
27 than "insurer," and throughout this chapter, the
28 revised law substitutes "health benefit plan issuer"
29 for "insurer." In addition, because the term "health
30 insurer" is only used in the definition of "insurer,"
31 the revised law omits the definition of "health
32 insurer" and includes the substance of the definition
33 in the definition of "health benefit plan issuer."
34 Comparable changes necessary to ensure consistent
35 terminology have been made throughout the chapter.

36 Revised Law

37 Sec. 1504.002. RULES. (a) The commissioner shall adopt
38 reasonable rules as necessary to implement this chapter and 42
39 U.S.C. Section 1396a(a)(60), including rules that define acts that
40 constitute unfair or deceptive practices under Subchapter I,
41 Chapter 541.

42 (b) The commissioner shall adopt rules that define

1 "comparable health coverage" in a manner that:

2 (1) is consistent with federal law; and

3 (2) complies with the requirements necessary to
4 maintain federal Medicaid funding. (V.T.I.C. Art. 3.96-8, Sec.
5 (c); Art. 3.96-10.)

6 Source Law

7 [Art. 3.96-8]

8 (c) The commissioner shall adopt rules to define
9 "comparable coverage" in a manner consistent with
10 federal law and that meet requirements to maintain
11 federal Medicaid funding.

12 Art. 3.96-10. The commissioner shall adopt
13 reasonable rules as necessary to implement this
14 subchapter and the requirements of 42 U.S.C. Section
15 1396a(a)(60), including rules defining acts that
16 constitute unfair or deceptive practices under Section
17 13, Article 21.21, of this code.

18 Revisor's Note

19 Section (c), V.T.I.C. Article 3.96-8, requires
20 the commissioner of insurance to adopt rules defining
21 "comparable coverage" in a manner that is consistent
22 with federal law. For consistency of terms between
23 state and federal laws, the revised law substitutes
24 "comparable health coverage" for "comparable
25 coverage" because that is the term used in 42 U.S.C.
26 Section 1396g-1 (providing a list of the
27 state-required medical child support laws).
28 Appropriate changes have been made throughout this
29 chapter.

30 Revised Law

31 Sec. 1504.003. VIOLATION OF CHAPTER: RELIEF AVAILABLE TO
32 INJURED PERSON. A health benefit plan issuer that violates this
33 chapter is subject to the same penalties, and an injured person has
34 the same rights and remedies, as those provided by Subchapter D,
35 Chapter 541. (V.T.I.C. Art. 3.96-9.)

36 Source Law

37 Art. 3.96-9. An insurer that violates this
38 subchapter is subject to the same penalties, and an
39 injured party has the same rights and remedies, as
40 those provided by Section 16, Article 21.21, of this

1 code.

2 [Sections 1504.004-1504.050 reserved for expansion]

3 SUBCHAPTER B. DUTIES OF HEALTH BENEFIT PLAN ISSUER

4 Revised Law

5 Sec. 1504.051. ENROLLMENT OF CERTAIN CHILDREN
6 REQUIRED. (a) A health benefit plan issuer shall permit a parent
7 to enroll a child in dependent health coverage offered through the
8 issuer regardless of any enrollment period restriction if the
9 parent is:

10 (1) eligible for dependent health coverage; and

11 (2) required by a court order or administrative order
12 to provide health insurance coverage for the child.

13 (b) A health benefit plan issuer shall enroll a child of a
14 parent described by Subsection (a) in dependent health coverage
15 offered through the issuer if:

16 (1) the parent does not apply to obtain health
17 coverage for the child through the issuer; and

18 (2) the child, a custodial parent of the child, or a
19 child support agency having a duty to collect or enforce support for
20 the child applies for the coverage. (V.T.I.C. Art. 3.96-3.)

21 Source Law

22 Art. 3.96-3. (a) If a parent eligible for
23 dependent health coverage through an insurer is
24 required by a court or administrative order to provide
25 health coverage for a child, the insurer shall permit
26 the parent to enroll the child without regard to any
27 enrollment period restriction.

28 (b) If a parent eligible for dependent health
29 coverage through an insurer is required by a court or
30 administrative order to provide health coverage for a
31 child and fails to apply to obtain the health insurance
32 coverage for the child, the insurer shall enroll the
33 child on application of a custodial parent of the
34 child, a child support agency having a duty to collect
35 or enforce support for the child, or the child.

36 Revised Law

37 Sec. 1504.052. CHILD RESIDING OUTSIDE SERVICE AREA;
38 COMPARABLE HEALTH COVERAGE REQUIRED. (a) A health benefit plan
39 issuer may not deny enrollment of a child under the health coverage
40 of the child's parent on the ground that the child does not reside
41 in the issuer's service area.

1 (b) A health benefit plan issuer may not enforce an
2 otherwise applicable provision of the health coverage that would
3 deny, limit, or reduce payment of a claim for a covered child who
4 resides outside the issuer's service area but inside the United
5 States.

6 (c) For a covered child who resides outside the health
7 benefit plan issuer's service area and whose coverage under a
8 policy or plan is required by a medical support order, the issuer
9 shall provide coverage that is comparable health coverage to that
10 provided to other dependents under the policy or plan.

11 (d) Comparable health coverage may include coverage in
12 which a health benefit plan issuer uses different procedures for
13 service delivery and health care provider reimbursement.
14 Comparable health coverage may not include coverage:

15 (1) that is limited to emergency services only; or

16 (2) for which the issuer charges a higher premium.

17 (V.T.I.C. Art. 3.96-2 (part); Art. 3.96-8, Secs. (a), (b).)

18 Source Law

19 Art. 3.96-2. An insurer may not deny enrollment
20 of a child under the health insurance coverage of the
21 child's parent on the ground that the child:

22 . . .
23 (4) does not reside . . . in the insurer's
24 service area; or

25 Art. 3.96-8. (a) An insurer shall provide
26 coverage for a covered child who resides outside the
27 insurer's service area, and whose coverage under a
28 policy or plan is required by a medical support order,
29 that is comparable coverage to that provided to other
30 dependents under the policy or plan. In this
31 subsection, "comparable coverage" may include
32 coverage under which an insurer uses different
33 procedures for service delivery and health care
34 provider reimbursement. The coverage may not be
35 limited to emergency services only. The coverage may
36 not include coverage for which the insurer charges a
37 higher premium.

38 (b) An insurer may not enforce otherwise
39 applicable provisions that would deny, limit, or
40 reduce payment for claims for a covered child who lives
41 outside the insurer's coverage territory but inside
42 the United States.

43 Revisor's Note

44 Section (b), V.T.I.C. Article 3.96-8, refers to a
45 health benefit plan issuer's "coverage territory."

1 The revised law substitutes "service area" for
2 "coverage territory" for consistency of terms in this
3 chapter.

4 Revised Law

5 Sec. 1504.053. CANCELLATION OR NONRENEWAL OF COVERAGE FOR
6 CERTAIN CHILDREN. (a) A health benefit plan issuer may not cancel
7 or refuse to renew health coverage provided to a child who is
8 enrolled or entitled to enrollment under this chapter unless
9 satisfactory written evidence is filed with the issuer showing
10 that:

11 (1) the court or administrative order that required
12 the coverage is not in effect; or

13 (2) the child:

14 (A) is enrolled in comparable health coverage; or

15 (B) will be enrolled in comparable health
16 coverage that takes effect not later than the effective date of the
17 cancellation or nonrenewal.

18 (b) For purposes of this section, a child is not enrolled or
19 entitled to enrollment under this chapter if the child's
20 eligibility for health coverage ends because the parent ceases to
21 be eligible for dependent health coverage. (V.T.I.C. Art. 3.96-4.)

22 Source Law

23 Art. 3.96-4. (a) An insurer may not cancel or
24 refuse to renew insurance coverage of a child entitled
25 to enrollment or enrolled under this subchapter unless
26 satisfactory written evidence is filed with the
27 insurer that shows that:

28 (1) the court order or administrative
29 order that required the coverage is no longer in
30 effect; or

31 (2) the child is enrolled in comparable
32 health insurance coverage or will be enrolled in
33 comparable coverage that will take effect not later
34 than the effective date of the cancellation or
35 nonrenewal.

36 (b) As used in this section, "a child entitled
37 to enrollment or enrolled under this subchapter" does
38 not include a child whose eligibility has terminated
39 because the parent eligible for dependent health
40 coverage is no longer eligible for such coverage.

41 Revised Law

42 Sec. 1504.054. CONTINUATION OR CONVERSION OF COVERAGE. (a)

1 If a child's eligibility for dependent health coverage ends because
2 the parent ceases to be eligible for the coverage and the coverage
3 provides for the continuation or conversion of the coverage for the
4 child, the health benefit plan issuer shall notify the custodial
5 parent and the child support agency of the costs and other
6 requirements for continuing or converting the coverage.

7 (b) The health benefit plan issuer shall, on application of
8 a parent of the child, a child support agency, or the child, enroll
9 or continue enrollment of a child whose eligibility for coverage
10 ended under Subsection (a). (V.T.I.C. Art. 3.96-5.)

11 Source Law

12 Art. 3.96-5. If dependent health coverage being
13 terminated pursuant to Subsection (b), Article 3.96-4,
14 of this code contains provisions for the continuation
15 or conversion of such coverage for the child, the
16 insurer shall notify the custodial parent and the
17 child support agency of the costs and other
18 requirements for extending or converting such
19 coverage, and shall enroll or continue enrollment of
20 the child on application of a parent of the child, a
21 child support agency, or the child.

22 Revisor's Note

23 V.T.I.C. Article 3.96-5 refers to requirements
24 for "extending or converting" health insurance
25 coverage. The revised law substitutes "continuing"
26 for "extending" for consistency of terms in this
27 section.

28 Revised Law

29 Sec. 1504.055. PROCEDURE FOR CLAIMS. (a) A health benefit
30 plan issuer that provides health coverage to a child through a
31 covered parent of the child shall:

32 (1) provide to each custodial parent of the child or to
33 an adult child documents and other information necessary for the
34 child to obtain benefits under the coverage, including:

- 35 (A) the name of the issuer;
- 36 (B) the number of the policy or evidence of
37 coverage;
- 38 (C) a copy of the policy or evidence of coverage

1 and schedule of benefits;

2 (D) a health coverage membership card;

3 (E) claim forms; and

4 (F) any other document or information necessary
5 to submit a claim in accordance with the issuer's policies and
6 procedures;

7 (2) permit a custodial parent, health care provider,
8 state agency that has been assigned medical support rights, or
9 adult child to submit claims for covered services without the
10 approval of the covered parent; and

11 (3) make payments on covered claims submitted in
12 accordance with this subsection directly to a custodial parent,
13 health care provider, adult child, or state agency making a claim.

14 (b) A health benefit plan issuer shall provide to a state
15 agency that provides medical assistance to the child or shall
16 provide to a child support agency that enforces medical support on
17 behalf of a child the information necessary to obtain reimbursement
18 of medical services provided to or paid on behalf of the child.
19 (V.T.I.C. Art. 3.96-6, Sec. (b); Art. 3.96-7.)

20 Source Law

21 [Art. 3.96-6]

22 (b) An insurer shall provide to a state agency
23 providing medical assistance, or to a child support
24 agency enforcing medical support, information as
25 necessary to facilitate reimbursement of medical
26 services provided to or paid on behalf of a child.

27 Art. 3.96-7. (a) If a child receives health
28 insurance coverage through the insurer of a parent of
29 the child, that insurer must provide information and
30 documents to each custodial parent or an adult child as
31 necessary for the child to obtain benefits through
32 that coverage, including:

33 (1) the name of the insurer;

34 (2) the number of the policy;

35 (3) a copy of the policy and schedule of
36 benefits;

37 (4) a health insurance membership card;

38 (5) claim forms; and

39 (6) any other information or document
40 necessary to submit a claim in accordance with the
41 insurer's policies and procedures.

42 (b) The insurer shall permit a custodial parent,
43 a health care provider, adult child, or a state agency
44 that has been assigned medical support rights to
45 submit claims for covered services without the
46 approval of the insured parent.

47 (c) The insurer shall make payments on covered

1 claims submitted in accordance with this article
2 directly to the custodial parent, health care
3 provider, adult child, or state agency making the
4 claim.

5 Revisor's Note

6 (1) Sections (a)(2) and (3), V.T.I.C. Article
7 3.96-7, refer to a "policy" in the context of providing
8 health coverage by a health benefit plan issuer. In
9 this chapter, "health benefit plan issuer" is defined
10 to include entities such as health maintenance
11 organizations. These entities generally do not
12 provide coverage through documents called "policies."
13 Consequently, the revised law adds a reference to
14 "evidence of coverage" because that is the name of the
15 document issued by a health maintenance organization.

16 (2) Section (a)(4), V.T.I.C. Article 3.96-7,
17 requires a health benefit plan issuer that provides
18 health coverage to provide a "health insurance
19 membership card." The revised law substitutes "health
20 coverage membership card" for the reason stated in the
21 revisor's note to Section 1504.001.

22 [Sections 1504.056-1504.100 reserved for expansion]

23 SUBCHAPTER C. PROHIBITED CONDUCT

24 Revised Law

25 Sec. 1504.101. DENIAL OF ENROLLMENT ON CERTAIN GROUNDS
26 PROHIBITED. A health benefit plan issuer may not deny enrollment
27 of a child under the health coverage of the child's parent on the
28 ground that the child:

29 (1) has a preexisting condition;

30 (2) was born out of wedlock;

31 (3) is not claimed as a dependent on the parent's
32 federal income tax return;

33 (4) does not reside with the parent; or

34 (5) receives or has applied for medical assistance.

35 (V.T.I.C. Art. 3.96-2 (part).)

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Source Law

Art. 3.96-2. An insurer may not deny enrollment of a child under the health insurance coverage of the child's parent on the ground that the child:
(1) has a preexisting condition;
(2) was born out of wedlock;
(3) is not claimed as a dependent on the parent's federal income tax return;
(4) does not reside with the parent or . . .
(5) is or has been an applicant for or recipient of medical assistance.

Revised Law

Sec. 1504.102. ASSIGNMENT OF MEDICAL SUPPORT RIGHTS: DIFFERENT REQUIREMENTS PROHIBITED. A health benefit plan issuer may not require a state agency that has been assigned the rights of an individual who is eligible for medical assistance and is covered for health benefits from the issuer to comply with a requirement that is different from a requirement imposed on an agent or assignee of any other covered individual. (V.T.I.C. Art. 3.96-6, Sec. (a).)

Source Law

Art. 3.96-6. (a) An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance and covered for health benefits from the insurer that are different from the requirements applicable to an agent or assignee of any other covered individual.

CHAPTER 1505. GROUP INSURANCE PLANS FOR PERSONS 65 YEARS OF AGE OR OLDER

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1 CHAPTER 1505. GROUP HEALTH INSURANCE PLANS FOR PERSONS 65 YEARS
2 OF AGE OR OLDER

3 Revised Law

4 Sec. 1505.001. DEFINITION. In this chapter, "health
5 insurer" means an insurance company authorized to provide a
6 hospital, surgical, and medical expense insurance plan in this
7 state, including:

- 8 (1) a stock insurance company;
- 9 (2) a reciprocal or interinsurance exchange;
- 10 (3) a Lloyd's plan;
- 11 (4) a fraternal benefit society;
- 12 (5) a stipulated premium company; and
- 13 (6) a mutual insurance company, including a statewide
14 mutual assessment company or a local mutual aid association.

15 (V.T.I.C. Art. 3.71, Sec. 1 (part).)

16 Source Law

17 Sec. 1. . . . insurance companies authorized to
18 [separately] do such an insurance business in this
19 state, including stock companies, reciprocals, or
20 inter-insurance exchanges, Lloyds' associations,
21 fraternal benefit societies and mutual companies of
22 all kinds, including state-wide mutual assessment
23 corporations and local mutual aid associations, and
24 stipulated premium companies, [may join together to
25 offer, sell and administer] hospital, surgical and
26 medical expense insurance plans

27 Revised Law

28 Sec. 1505.002. PLANS FOR CERTAIN PERSONS 65 YEARS OF AGE OR
29 OLDER. (a) Two or more health insurers may provide a hospital,
30 surgical, and medical expense insurance plan under a group
31 insurance policy that covers residents of this state who are at
32 least 65 years of age and the spouses of those residents.

33 (b) The participating health insurers may enter into
34 agreements regarding matters within the scope of this chapter,
35 including:

- 36 (1) premium rates;
- 37 (2) policy provisions; and
- 38 (3) sales, administrative, technical, and accounting

1 procedures.

2 (c) Each participating health insurer is subject to
3 regulation under the laws of this state and is severally liable on a
4 group insurance policy issued under this chapter. (V.T.I.C. Art.
5 3.71, Secs. 1 (part), 2 (part).)

6 Source Law

7 Art. 3.71

8 Sec. 1. Notwithstanding any contrary or
9 inconsistent provision of any law, two or more
10 [insurance companies authorized to] separately [do
11 such an insurance business in this state,] . . . may
12 join together to offer, sell and administer hospital,
13 surgical and medical expense insurance plans under a
14 group policy covering residents of this state who are
15 sixty-five (65) years of age and older and their
16 spouses on which policy each insurance carrier shall
17 be severally liable, and such companies may agree with
18 respect to premium rates, policy provisions, sales,
19 administrative, technical and accounting procedures
20 and other matters within the scope of this
21 Article. . . .

22 Sec. 2. The insurance companies participating
23 in the insurance plans authorized by this Article
24 shall be subject to regulation under the laws of this
25 state, and

26 Revisor's Note

27 Section 1, V.T.I.C. Article 3.71, refers to an
28 authorization to engage in the business of insurance
29 "[n]otwithstanding any contrary or inconsistent
30 provision of any law." The revised law omits the
31 quoted statement. The revised law is sufficient and
32 specific authority for a health insurer to act as
33 specified, and it is unnecessary to refer to other,
34 more general provisions to which the revised law acts
35 as an exception.

36 Revised Law

37 Sec. 1505.003. APPLICATION AND OTHER EVIDENCE OF INSURANCE
38 FORMS. An application, policy, certificate, or other evidence of
39 insurance form for an insurance plan under this chapter is subject
40 to Chapter 1701. (V.T.I.C. Art. 3.71, Sec. 2 (part).)

41 Source Law

42 Sec. 2. . . . the forms of the applications,
43 certificates, policies and other evidence of such
44 insurance shall be subject to the requirements of

1 Article 3.42 of this Insurance Code. . . .

2 Revised Law

3 Sec. 1505.004. EXECUTION OF POLICY. An authorized person
4 may execute an insurance policy subject to this chapter on behalf of
5 the participating health insurers. (V.T.I.C. Art. 3.71, Sec. 1
6 (part).)

7 Source Law

8 Sec. 1. . . . Any such policy may be executed
9 on behalf of the insurance companies by a duly
10 authorized person and

11 Revisor's Note

12 Section 1, V.T.I.C. Article 3.71, provides in
13 part that a group insurance policy issued under that
14 article is not required to be countersigned on behalf
15 of a participating insurer by a resident agent, thus
16 acting as an exception to the general requirement,
17 established under former V.T.I.C. Article 21.09, that
18 a resident agent countersign certain health insurance
19 policies on behalf of the issuing insurer. The revised
20 law omits this provision as unnecessary. V.T.I.C.
21 Article 21.09 was repealed by the 75th Legislature in
22 1997, and there are no remaining countersignature
23 requirements for group health insurance policies. The
24 omitted law reads:

25 Sec. 1 . . . [Any such policy may be
26 executed on behalf of the insurance
27 companies by a duly authorized person and]
28 need not be countersigned on behalf of any
29 such company by a resident agent. . . .

30 Revised Law

31 Sec. 1505.005. USE OF UNINCORPORATED ENTITY. (a) The
32 participating health insurers may issue the group insurance policy
33 in their own names or in the name of an unincorporated association,
34 trust, or other organization formed for the sole purposes of this
35 chapter and evidenced by a written contract executed by the
36 insurers. An unincorporated association, trust, or other
37 organization formed under this subsection may sue and be sued in the

1 name of the association, trust, or organization.

2 (b) A person licensed as a general life, accident, and
3 health agent or as a general property and casualty agent under
4 Chapter 4051 or 4054 may act in the licensed capacity in connection
5 with an insurance policy or a certificate of insurance issued by an
6 unincorporated association, trust, or other organization formed
7 under Subsection (a). The agent is not required to notify the
8 department that the person has been appointed to act for that
9 purpose. (V.T.I.C. Art. 3.71, Secs. 1 (part), 3.)

10 Source Law

11 Sec. 1. . . . Such companies may issue such
12 insurance policies in their own names or in the name of
13 an unincorporated association, trust, or other
14 organization formed for the sole purposes of this
15 Article and evidenced by a contract in writing
16 executed by the participating insurance companies,
17 and Any person who is licensed as a general
18 life, accident, and health agent or as a general
19 property and casualty agent under Article 21.07-1 or
20 21.14 of this code may act as such agent in connection
21 with policies of insurance or certificates of
22 insurance issued by any unincorporated association,
23 trust or other organization formed for the sole
24 purposes of this Article without the necessity of
25 notifying the department that such person is appointed
26 to so act.

27 Sec. 3. Any unincorporated association, trust or
28 other organization formed under the authority of this
29 Article may sue and be sued in its association, trust
30 or organization name.

31 Revisor's Note

32 Section 1, V.T.I.C. Article 3.71, validated
33 certain contracts that established unincorporated
34 associations, trusts, or other organizations to
35 provide the coverage authorized under V.T.I.C. Article
36 3.71 and that were entered into before the effective
37 date of that article. The revised law omits this
38 provision as executed because the provision served its
39 purpose on the day it took effect. Section
40 311.031(a)(2), Government Code (Code Construction
41 Act), provides that the repeal of a statute does not
42 affect any validation previously made under the
43 statute. That section applies to the revised law. The

1 omitted law reads:

2 Sec. 1. . . . any unincorporated
3 associations, trusts, or other
4 organizations heretofore formed for the
5 sole purpose of this Article and evidenced
6 by a contract in writing executed by the
7 participating insurance companies is hereby
8 ratified, confirmed and approved and
9 validated from the date of its
10 formation. . . .

11 Revised Law

12 Sec. 1505.006. REQUIRED FILINGS; DEPARTMENT APPROVAL. (a)
13 The participating health insurers shall provide for the filing with
14 the department on behalf of the insurers of:

15 (1) a copy of any contract of association or
16 organization or trust agreement entered into by the insurers under
17 this chapter;

18 (2) the schedule of premium rates to be charged for the
19 insurance coverage; and

20 (3) the plan for operating and marketing the
21 insurance.

22 (b) Except as provided by Subsection (c), a contract,
23 schedule, or plan described by Subsection (a) may not be effective
24 until approved by the commissioner.

25 (c) A contract, schedule, or plan described by Subsection
26 (a) that is not approved or disapproved in a written order of the
27 commissioner on or before the 30th day after the date on which the
28 document is filed with the department is considered approved on the
29 31st day after the date of filing. (V.T.I.C. Art. 3.71, Sec. 2
30 (part).)

31 Source Law

32 Sec. 2. . . . There shall be filed with the
33 State Board of Insurance by or on behalf of such
34 companies a true copy of any contract of association or
35 organization or trust agreement entered into by such
36 companies pursuant to this Article, the schedule of
37 premium rates to be charged for the insurance, and the
38 plan for operating and marketing such insurance. No
39 such contract, schedule or plan shall be effective
40 unless and until approved by the State Board of
41 Insurance, provided, however, that at the expiration
42 of thirty days after the filing of any such contract,
43 schedule or plan, it shall be deemed approved unless
44 prior thereto it has been affirmatively approved or

1 disapproved by written order of said Board. . . .

2 Revisor's Note

3 (1) Section 2, V.T.I.C. Article 3.71, refers to
4 the "State Board of Insurance." Chapter 685, Acts of
5 the 73rd Legislature, Regular Session, 1993, abolished
6 that board and transferred its functions to the
7 commissioner of insurance and the Texas Department of
8 Insurance. Throughout this chapter, references to the
9 State Board of Insurance have been changed
10 appropriately.

11 (2) Section 2, V.T.I.C. Article 3.71, refers to
12 a "true copy" of a contract. The revised law omits
13 "true" as unnecessary because the word does not add to
14 the clear meaning of the law. For example, a document
15 purporting to be a copy is not a copy if it is different
16 from the original document.

17 Revised Law

18 Sec. 1505.007. EFFECT OF COMMISSIONER DISAPPROVAL. If,
19 after notice and public hearing, the commissioner determines under
20 reasonable assumptions that a premium rate charged for the
21 insurance coverage offered under this chapter or the plan for
22 operating and marketing that insurance is excessive, inadequate, or
23 contrary to the public interest or that any activity or practice
24 performed in connection with the insurance is unfair, unreasonable,
25 or contrary to the public interest, the commissioner shall:

26 (1) enter an order containing the commissioner's
27 determination and disapproving the premium rate or plan or the
28 activity or practice; and

29 (2) require the discontinuance of the premium rate,
30 plan, activity, or practice within a period that is not less than 30
31 days after the date of the commissioner's order containing the
32 determination. (V.T.I.C. Art. 3.71, Sec. 2 (part).)

33 Source Law

34 Sec. 2. . . . If after notice and public
35 hearing the said Board shall at any time find that

1 under reasonable assumptions the premium rates charged
2 for such insurance, or the plan for operating and
3 marketing same are excessive, inadequate or contrary
4 to the public interest, or that any activity or
5 practice in connection with such insurance is unfair,
6 unreasonable or contrary to the public interest, it
7 shall disapprove such premium rates or plan or such
8 activity or practice and shall require the
9 discontinuance thereof within not less than thirty
10 days from the date of its order containing such
11 finding.

12 Revised Law

13 Sec. 1505.008. EXEMPTION FROM PREMIUM TAXES. Each premium
14 received for group insurance coverage authorized by this chapter is
15 exempt from any premium tax imposed by any other law of this state.
16 (V.T.I.C. Art. 3.71, Sec. 4.)

17 Source Law

18 Sec. 4. Notwithstanding any contrary or
19 inconsistent provision of any law of this state, all
20 premiums received on account of the group insurance
21 authorized by this Article are hereby expressly
22 exempted and excluded from any and all premium taxes of
23 any kind imposed by any other law of this state.

24 Revisor's Note

25 Section 4, V.T.I.C. Article 3.71, provides that
26 certain premiums are exempt from premium taxes
27 "[n]otwithstanding any contrary or inconsistent
28 provision of any law of this state." The revised law
29 omits the quoted provision for the reason stated in the
30 revisor's note to Section 1505.002.

31 Revised Law

32 Sec. 1505.009. EXEMPTION FROM CERTAIN ANTITRUST
33 REQUIREMENTS. An association, trust, or other organization formed
34 and operated in accordance with this chapter or an insurance
35 business conducted in accordance with this chapter is not
36 considered a combination in restraint of trade, an illegal
37 monopoly, or an attempt to lessen competition or fix prices
38 arbitrarily and does not otherwise violate the antitrust laws of
39 this state. (V.T.I.C. Art. 3.71, Sec. 5.)

40 Source Law

41 Sec. 5. No association, trust or other
42 organization formed and operated in accordance with
43 this Article and no insurance business conducted in

1 accordance with this Article shall be deemed to be a
2 combination in restraint of trade, or an illegal
3 monopoly, or an attempt to lessen competition or fix
4 prices arbitrarily or to otherwise violate the
5 anti-trust laws of this state.

6 CHAPTER 1506. TEXAS HEALTH INSURANCE RISK POOL

7 SUBCHAPTER A. GENERAL PROVISIONS

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15 [Sections 1506.008-1506.050 reserved for expansion]

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1 CHAPTER 1506. TEXAS HEALTH INSURANCE RISK POOL

2 SUBCHAPTER A. GENERAL PROVISIONS

3 Revised Law

4 Sec. 1506.001. DEFINITIONS. In this chapter:

5 (1) "Board" means the board of directors of the pool.

6 (2) "Health benefit arrangement" means a plan,
7 program, contract, or other arrangement through which an employer
8 provides health care services, other than health care services
9 covered through a health benefit plan issuer, to the employer's
10 officers, employees, or other personnel.

11 (3) "Health benefit plan issuer" means an entity that
12 provides health benefit plan coverage in this state, including
13 stop-loss or excess loss insurance. The term includes:

14 (A) an insurance company;

15 (B) a group hospital service corporation
16 operating under Chapter 842;

17 (C) a fraternal benefit society operating under
18 Chapter 885;

19 (D) a stipulated premium company operating under
20 Chapter 884;

21 (E) a health maintenance organization;

22 (F) an approved nonprofit health corporation
23 that holds a certificate of authority under Chapter 844;

24 (G) an eligible surplus lines insurer operating
25 under Chapter 981;

26 (H) an insurer providing stop-loss or excess loss
27 insurance to physicians, health care providers, or hospitals or to
28 any benefit arrangements to the extent permitted by Section 3,
29 Employee Retirement Income Security Act of 1974 (29 U.S.C. Section
30 1002); and

31 (I) any other entity providing a plan of health
32 insurance or health benefits subject to state insurance regulation.

33 (4) "Health maintenance organization" means an entity
34 that holds a certificate of authority to operate under Chapter 843.

1 (5) "Hospital" means a hospital for which a license is
2 issued under Chapter 241, Health and Safety Code, or that is owned
3 or operated by the federal or state government.

4 (6) "Physician" means a person licensed to practice
5 medicine in this state under Subtitle B, Title 3, Occupations Code.

6 (7) "Pool" means the Texas Health Insurance Risk Pool.
7 (V.T.I.C. Art. 3.77, Secs. 2(2), (8), (9), (11), (12), (14), (16).)

8 Source Law

9 Sec. 2. In this article:

10 (2) "Board" means the board of directors
11 of the pool.

12 (8) "Health maintenance organization"
13 means a health maintenance organization that has a
14 certificate of authority to operate in this state
15 under the Texas Health Maintenance Organization Act
16 (Chapter 20A, Vernon's Texas Insurance Code).

17 (9) "Hospital" means a licensed public or
18 private institution as defined by Chapter 241, Health
19 and Safety Code, and any hospital owned or operated by
20 the federal or state government.

21 (11) "Insurer" means any entity that
22 provides health insurance in this state, including
23 stop-loss or excess loss insurance. For the purposes
24 of this article, "insurer" includes but is not limited
25 to an insurance company; a health maintenance
26 organization operating under the Texas Health
27 Maintenance Organization Act (Chapter 20A, Vernon's
28 Texas Insurance Code); an approved nonprofit health
29 corporation; a fraternal benefit society; a stipulated
30 premium insurance company; a group hospital service
31 corporation subject to Chapter 20 of this code; a
32 surplus lines carrier; an insurer providing stop-loss
33 or excess loss insurance to physicians, health care
34 providers, hospitals, or to any benefit arrangements
35 to the extent permitted by Section 3, Employee
36 Retirement Income Security Act of 1974 (29 U.S.C.
37 Section 1002); and any other entity providing a plan of
38 health insurance or health benefits subject to state
39 insurance regulation.

40 (12) "Insurance arrangement" means a plan,
41 program, contract, or other arrangement through which
42 health care services are provided by an employer to its
43 officers, employees, or other personnel but does not
44 include health care services covered through an
45 insurer.

46 (14) "Physician" means a person licensed
47 to practice medicine in this state under the Medical
48 Practice Act (Article 4495b, Vernon's Texas Civil
49 Statutes).

50 (16) "Pool" means the Texas Health
51 Insurance Risk Pool.

1 Revisor's Note

2 (1) Sections 2(3) and (4), V.T.I.C. Article
3 3.77, provide definitions of "commissioner" and
4 "department." The revised law omits those definitions
5 as unnecessary because Section 31.001 of this code
6 contains definitions for those terms that are
7 applicable throughout the code. The omitted law
8 reads:

9 (3) "Commissioner" means the
10 commissioner of insurance.

11 (4) "Department" means the
12 Texas Department of Insurance.

13 (2) Section 2(10), V.T.I.C. Article 3.77,
14 defines "insured" to mean a person who is "a resident
15 of this state and a citizen of the United States and
16 . . . eligible to receive benefits from the pool."
17 Chapter 1084, Acts of the 77th Legislature, Regular
18 Session, 2001, amended Section 10, V.T.I.C. Article
19 3.77, to allow certain individuals legally domiciled
20 in this state to be eligible to receive benefits from
21 the pool regardless of whether the individuals are
22 citizens of the United States. The revised law omits
23 the definition of "insured" because it conflicts with
24 the clear intent of the amendment to Section 10 and
25 thus was impliedly repealed. Also, the meaning of the
26 term as used in the revised law is clear without a
27 definition. The omitted law reads:

28 (10) "Insured" means a person
29 who is a resident of this state and a
30 citizen of the United States and who is
31 eligible to receive benefits from the pool.
32 The term "insured" may include dependents
33 and family members.

34 (3) Section 2(11), V.T.I.C. Article 3.77,
35 provides a definition of "insurer" and Section 2(12),
36 V.T.I.C. Article 3.77, provides a definition of
37 "insurance arrangement." The revised law substitutes
38 "health benefit plan issuer" for "insurer" because the

1 definition of "insurer" includes entities, such as
2 health maintenance organizations, that provide health
3 coverage but are not insurers. Consequently, "health
4 benefit plan issuer" is a more accurate term.
5 Likewise, the revised law substitutes "health benefit
6 arrangement" for "insurance arrangement" because the
7 definition of "insurance arrangement" refers to both
8 insurance arrangements and other arrangements for
9 health care services that are not insurance
10 arrangements. The substitution of these terms, as
11 well as related changes necessary to ensure
12 consistency in terminology, is made throughout this
13 chapter.

14 (4) Section 2(11), V.T.I.C. Article 3.77,
15 provides that the defined term "includes but is not
16 limited to" several types of entities. The phrase "but
17 is not limited to" is omitted from the revised law as
18 unnecessary because Section 311.005(13), Government
19 Code (Code Construction Act), and Section 312.011(19),
20 Government Code, provide that "includes" and
21 "including" are terms of enlargement and not of
22 limitation and do not create a presumption that
23 components not expressed are excluded. For clarity
24 and consistency, the revised law also adds for four of
25 the entities listed in Section 2(11) (an approved
26 nonprofit health corporation, a fraternal benefit
27 society, a stipulated premium company, and an eligible
28 surplus lines insurer) references to the chapters of
29 this code that provide the authority for the operation
30 of each entity. The revised law substitutes "eligible
31 surplus lines insurer" for "surplus lines carrier" for
32 consistency with the terminology used in Chapter 981
33 of this code.

34 (5) Section 2(13), V.T.I.C. Article 3.77,

1 provides a definition of "Medicare." The revised law
2 omits that definition as unnecessary because the term
3 is commonly used in other statutes of the state without
4 being defined, and its meaning is unambiguous. The
5 omitted law reads:

6 (13) "Medicare" means coverage
7 provided by Part A and Part B, Title XVIII,
8 Social Security Act (42 U.S.C. Section
9 1395c et seq.).

10 (6) Section 2(14), V.T.I.C. Article 3.77,
11 refers to the Medical Practice Act (Article 4495b,
12 Vernon's Texas Civil Statutes). That statute was
13 codified in 1999 as Subtitle B, Title 3, Occupations
14 Code. The revised law is drafted accordingly.

15 Revised Law

16 Sec. 1506.002. DEFINITION OF HEALTH BENEFIT PLAN. (a) In
17 this chapter, "health benefit plan" means an individual or group
18 health benefit plan and includes:

19 (1) a hospital or medical expense incurred policy;

20 (2) coverage of medical or health care services
21 offered by:

22 (A) a group hospital service corporation
23 operating under Chapter 842;

24 (B) a fraternal benefit society operating under
25 Chapter 885;

26 (C) a stipulated premium company operating under
27 Chapter 884;

28 (D) a health maintenance organization;

29 (E) a multiple employer welfare arrangement
30 subject to Chapter 846; or

31 (F) an approved nonprofit health corporation
32 that holds a certificate of authority under Chapter 844; and

33 (3) any other health care plan or arrangement that
34 pays for or furnishes medical or health care services by insurance
35 or otherwise.

1 (b) In this chapter, "health benefit plan" does not include:

2 (1) short-term insurance;

3 (2) accident insurance;

4 (3) a plan providing coverage only for dental or
5 vision care;

6 (4) fixed indemnity insurance, including hospital
7 indemnity insurance;

8 (5) credit insurance;

9 (6) long-term care insurance;

10 (7) disability income insurance;

11 (8) other limited benefit coverage, including
12 specified disease coverage;

13 (9) coverage issued as a supplement to liability
14 insurance;

15 (10) insurance arising out of a workers' compensation
16 or similar law;

17 (11) automobile medical payment insurance; or

18 (12) insurance coverage under which benefits are
19 payable with or without regard to fault and that is statutorily
20 required to be contained in a liability insurance policy or
21 equivalent self-insurance. (V.T.I.C. Art. 3.77, Sec. 2(7).)

22 Source Law

23 Sec. 2. In this article:

24 (7) "Health insurance" means individual or
25 group health insurance and includes any hospital and
26 medical expense incurred policy, a fraternal benefit
27 society, a stipulated premium company, an approved
28 nonprofit health corporation, health maintenance
29 organization subscriber contract, coverage by a group
30 hospital service plan, a multiple employer welfare
31 arrangement subject to Subchapter I of this chapter,
32 or any other health care plan or arrangement that pays
33 for or furnishes medical or health care services
34 whether by insurance or otherwise. The term does not
35 include short-term, accident, dental-only,
36 vision-only, fixed indemnity, including hospital
37 indemnity insurance, credit insurance, long-term
38 care, disability income, or other limited benefit
39 insurance, including specified disease insurance,
40 coverage issued as a supplement to liability
41 insurance, insurance arising out of a workers'
42 compensation or similar law, automobile
43 medical-payment insurance, or insurance under which
44 benefits are payable with or without regard to fault

1 and which is statutorily required to be contained in
2 any liability insurance policy or equivalent
3 self-insurance.

4 Revisor's Note

5 (1) Section 2(7), V.T.I.C. Article 3.77,
6 defines "health insurance" to include any "health care
7 plan or arrangement that pays for or furnishes medical
8 or health care services whether by insurance or
9 otherwise." The revised law substitutes "health
10 benefit plan" for "health insurance" throughout this
11 chapter because the definition includes more than
12 insurance, and the substituted term is more accurate.
13 The revised law also makes related changes throughout
14 this chapter as necessary to ensure consistency in
15 terminology.

16 (2) Section 2(7), V.T.I.C. Article 3.77, lists
17 several entities that provide health insurance. For
18 clarity and consistency, the revised law adds for four
19 of those entities (an approved nonprofit health
20 corporation, a fraternal benefit society, a stipulated
21 premium company, and a group hospital service
22 corporation) references to the chapters of this code
23 that provide the authority for the operation of each
24 entity.

25 Revised Law

26 Sec. 1506.003. DEFINITION OF DEPENDENT. In this chapter,
27 "dependent" means:

28 (1) a resident spouse or unmarried child younger than
29 25 years of age; or

30 (2) a child who is:

31 (A) a full-time student younger than 25 years of
32 age who is financially dependent on the parent;

33 (B) 18 years of age or older and is an individual
34 for whom a person may be obligated to pay child support; or

35 (C) disabled and dependent on the parent

1 regardless of the age of the child. (V.T.I.C. Art. 3.77, Sec.
2 2(5).)

3 Source Law

4 Sec. 2. In this article:

5 (5) "Dependent" means a resident spouse or
6 unmarried child younger than 25 years of age, a child
7 who is a full-time student younger than 25 years of age
8 and who is financially dependent upon the parent, a
9 child who is 18 years of age or older and for whom a
10 person may be obligated to pay child support, or a
11 child of any age who is disabled and dependent upon the
12 parent.

13 Revised Law

14 Sec. 1506.004. AUDIT OF POOL. (a) Annually, the state
15 auditor shall conduct a special audit of the pool under Chapter 321,
16 Government Code. The special audit must include a financial audit
17 and an economy and efficiency audit.

18 (b) The state auditor shall report the cost of each audit
19 conducted under this section to the board and the comptroller. The
20 board shall remit that amount to the comptroller. (V.T.I.C. Art.
21 3.77, Sec. 15.)

22 Source Law

23 Sec. 15. (a) The state auditor shall conduct
24 annually a special audit of the pool under Chapter 321,
25 Government Code. The state auditor's report shall
26 include a financial audit and an economy and
27 efficiency audit.

28 (b) The state auditor shall report the cost of
29 each audit conducted under this article to the board
30 and the comptroller, and the board shall remit that
31 amount to the comptroller for deposit to the general
32 revenue fund.

33 Revisor's Note

34 Section 15(b), V.T.I.C. Article 3.77, requires
35 money for the cost of an audit to be remitted to the
36 comptroller "for deposit to the general revenue fund."
37 The revised law omits the quoted provision as
38 unnecessary. Section 404.094, Government Code,
39 requires all money collected or received by a state
40 agency, including the comptroller, to be deposited to
41 the credit of the general revenue fund. It is
42 unnecessary to repeat that requirement in this

1 chapter.

2 Revised Law

3 Sec. 1506.005. RULES. The commissioner may adopt rules
4 necessary and proper to implement this chapter. (V.T.I.C. Art.
5 3.77, Sec. 8 (part).)

6 Source Law

7 Sec. 8. The commissioner . . . may adopt other
8 rules as are necessary and proper to implement this
9 article. . . .

10 Revised Law

11 Sec. 1506.006. COMPLAINT PROCEDURES. (a) An applicant
12 for or participant in coverage from the pool is entitled to have
13 complaints against the pool reviewed by a grievance committee
14 appointed by the board.

15 (b) The grievance committee shall report to the board after
16 completion of the review of each complaint.

17 (c) The board shall retain each written complaint
18 concerning the pool at least until the third anniversary of the date
19 the pool received the complaint. (V.T.I.C. Art. 3.77, Sec. 14.)

20 Source Law

21 Sec. 14. An applicant or participant in coverage
22 from the pool is entitled to have complaints against
23 the pool reviewed by a grievance committee appointed
24 by the board. The grievance committee shall report to
25 the board after completion of the review of each
26 complaint. The board shall retain all written
27 complaints regarding the pool at least until the third
28 anniversary of the date the pool received the
29 complaint.

30 Revised Law

31 Sec. 1506.007. PROVISION OF INFORMATION ABOUT POOL. (a) A
32 health benefit plan issuer may provide to its insureds and
33 enrollees a notice relating to the existence of the pool that
34 contains the address from which an insured or enrollee may obtain
35 information about the coverage offered by the pool, the eligibility
36 for and cost of the coverage, and other information that allows an
37 insured or enrollee to compare the issuer's health benefit plan
38 coverage provided to the insured or enrollee with the coverage
39 offered by the pool.

1 (b) A health benefit plan issuer providing notice under this
2 section shall provide the notice as prescribed by the commissioner.

3 (c) A health benefit plan issuer does not incur any
4 liability solely for providing notice under this section.
5 (V.T.I.C. Art. 3.77, Secs. 2(1), 16(a), (b) (part).)

6 Source Law

7 Sec. 2. In this article:

8 (1) "Benefits plan" means coverage to be
9 offered by the pool to eligible persons under Section
10 11 of this article.

11 Sec. 16. (a) An insurer may provide a
12 notification to its insureds regarding the creation of
13 the Texas Health Insurance Risk Pool and the address
14 for information on cost, coverage, eligibility, and
15 other information where an insured can compare his or
16 her current health insurance with the benefits plan
17 offered by the pool. The insurer shall not incur any
18 liability solely for providing such notification.

19 (b) An insurer providing notice under
20 Subsection (a) shall provide such notice as prescribed
21 by the commissioner. . . .

22 Revisor's Note

23 (1) Section 16(a), V.T.I.C. Article 3.77,
24 refers to an "insured." The revised law adds a
25 reference to an "enrollee" because this chapter
26 applies to health maintenance organizations and
27 similar entities. "Enrollee" is the proper term to
28 refer to an individual covered under a benefit plan
29 provided by a health maintenance organization.

30 (2) Section 16(b), V.T.I.C. Article 3.77, in the
31 second sentence, provides authority for the
32 commissioner to adopt rules to implement that section.
33 The revised law omits that provision as unnecessary
34 because Section 8 of Article 3.77, revised in relevant
35 part as Section 1506.005, provides that authority for
36 the entire article. The omitted law reads:

37 (b) . . . The commissioner may
38 promulgate rules to implement this section.

39 [Sections 1506.008-1506.050 reserved for expansion]

1 SUBCHAPTER B. BOARD OF DIRECTORS

2 Revised Law

3 Sec. 1506.051. GOVERNANCE OF POOL; BOARD MEMBERSHIP. (a)
4 The pool is governed by a board of directors.

5 (b) The board consists of nine members appointed by the
6 commissioner as follows:

7 (1) at least two, but not more than four, members must
8 be individuals who are affiliated with a health benefit plan issuer
9 authorized to write health benefit plans in this state;

10 (2) at least two of the members must be individuals or
11 the parents of individuals who are covered by the pool or are
12 reasonably expected to qualify for coverage by the pool; and

13 (3) the other members of the board may be selected from
14 individuals such as:

15 (A) a physician licensed to practice in this
16 state by the Texas State Board of Medical Examiners;

17 (B) a hospital administrator;

18 (C) an advanced nurse practitioner; or

19 (D) a representative of the public who is not:

20 (i) employed by or affiliated with an
21 insurance company or insurance plan, group hospital service
22 corporation, or health maintenance organization; or

23 (ii) licensed as, employed by, or
24 affiliated with a physician, hospital, or other health care
25 provider.

26 (c) For purposes of Subsection (b), an individual who is
27 required to register under Chapter 305, Government Code, because of
28 the individual's activities with respect to health benefit
29 plan-related matters is affiliated with a health benefit plan
30 issuer.

31 (d) An individual is not disqualified under Subsection
32 (b)(3)(D)(i) from representing the public if the individual's only
33 affiliation with an insurance company or insurance plan, group
34 hospital service corporation, or health maintenance organization

1 is as an insured or as an individual who has coverage through a plan
2 provided by the corporation or organization. (V.T.I.C. Art. 3.77,
3 Secs. 4(a), (b) (part), (c), (d).)

4 Source Law

5 Sec. 4. (a) The pool is governed by a board of
6 directors composed of nine members.

7 (b) The commissioner shall appoint members of
8 the board . . . as provided by this section.

9 (c) The board shall be composed of:

10 (1) at least two persons affiliated with
11 an insurer admitted and authorized to write health
12 insurance in this state, but no more than four such
13 persons;

14 (2) at least two persons who are insureds
15 or parents of insureds or who are reasonably expected
16 to qualify for coverage by the pool;

17 (3) the remaining members of the board may
18 be selected from individuals such as a physician
19 licensed to practice in this state by the Texas State
20 Board of Medical Examiners, a hospital administrator,
21 an advanced nurse practitioner, or representatives of
22 the general public who are not employed by or
23 affiliated with an insurance company or plan, group
24 hospital service corporation, or health maintenance
25 organization or licensed as or employed by or
26 affiliated with a physician, hospital, or other health
27 care provider. A representative of the general public
28 does include a person whose only affiliation with an
29 insurance company or plan, group hospital service
30 corporation, or health maintenance organization is as
31 an insured or person who has coverage through a plan
32 provided by the corporation or organization.

33 (d) For purposes of this section, an individual
34 required to register with the secretary of state under
35 Chapter 305, Government Code, because of the
36 individual's activities with respect to health
37 insurance-related matters is a person affiliated with
38 an insurer.

39 Revisor's Note

40 Section 4(d), V.T.I.C. Article 3.77, refers to an
41 individual "required to register with the secretary of
42 state under Chapter 305, Government Code." The
43 revised law omits the reference to the secretary of
44 state because under Chapter 304, Acts of the 72nd
45 Legislature, Regular Session, 1991, an individual
46 formerly required to register with the secretary of
47 state must now register with the Texas Ethics
48 Commission under Chapter 305, Government Code. A
49 reference to the Texas Ethics Commission is
50 unnecessary because Chapter 305, Government Code,

1 provides for registration only with that agency.

2 Revised Law

3 Sec. 1506.052. PRESIDING OFFICER. The commissioner shall
4 designate one member of the board to serve as presiding officer at
5 the pleasure of the commissioner. (V.T.I.C. Art. 3.77, Sec. 4(g).)

6 Source Law

7 (g) The commissioner shall designate one of the
8 commissioner's appointees to the board to serve as
9 chairman. The chairman serves in that capacity at the
10 pleasure of the commissioner.

11 Revisor's Note

12 Section 4(g), V.T.I.C. Article 3.77, refers to
13 the "chairman" of the board. The revised law
14 substitutes "presiding officer" for that term because,
15 in context, the term has the same meaning, and
16 "presiding officer" is more modern and is gender
17 neutral.

18 Revised Law

19 Sec. 1506.053. TERMS; VACANCY. (a) Members of the board
20 serve staggered six-year terms.

21 (b) The commissioner shall fill a vacancy on the board by
22 appointing, for the unexpired term, an individual who has the
23 appropriate qualifications to fill that position. (V.T.I.C. Art.
24 3.77, Secs. 4(b) (part), (e).)

25 Source Law

26 (b) . . . for staggered six-year terms

27 (e) If a vacancy occurs on the board, the
28 commissioner shall fill the vacancy for the unexpired
29 term with a person who has the appropriate
30 qualifications to fill that position on the board.

31 Revised Law

32 Sec. 1506.054. PER DIEM; REIMBURSEMENT. A member of the
33 board is entitled to:

34 (1) a per diem in the amount provided by the General
35 Appropriations Act for state officials for each day the member
36 performs duties as a board member; and

37 (2) reimbursement of expenses incurred while

1 performing duties as a board member in the amount provided by the
2 General Appropriations Act for state officials. (V.T.I.C. Art.
3 3.77, Sec. 4(f).)

4 Source Law

5 (f) Each member of the board is entitled to be
6 paid a per diem for each day on which the member
7 performs his duties as a member of the board and to
8 reimbursement of his expenses while engaged in
9 performing his duties as a member of the board. The
10 amount of per diem and the amount of reimbursement for
11 expenses is the same as provided by the General
12 Appropriations Act for state officials.

13 Revised Law

14 Sec. 1506.055. MEMBER'S IMMUNITY. (a) A member of the
15 board is not liable for an act or omission made in good faith in the
16 performance of powers and duties under this chapter.

17 (b) A cause of action does not arise against a member of the
18 board for an act or omission described by Subsection (a). (V.T.I.C.
19 Art. 3.77, Sec. 4(h).)

20 Source Law

21 (h) A member of the board of directors is not
22 liable for an action or omission performed in good
23 faith in the performance of powers and duties under
24 this article, and cause of action does not arise
25 against a member for the action or omission.

26 Revised Law

27 Sec. 1506.056. ADJUSTMENTS. (a) The board may adjust
28 deductibles, the amounts of stop-loss coverage, and the periods
29 governing preexisting conditions under Section 1506.155 to
30 preserve the financial integrity of the pool.

31 (b) Not later than the 30th day after the date the board
32 makes an adjustment under this section, the board shall submit to
33 the commissioner a written report containing a description of and
34 the reasons for the adjustment. (V.T.I.C. Art. 3.77, Sec. 11(c).)

35 Source Law

36 (c) The board may adjust deductibles, the
37 amounts of stop-loss coverage, and the time periods
38 governing preexisting conditions under Section 12 of
39 this article to preserve the financial integrity of
40 the pool. If the board makes such an adjustment it
41 shall report in writing that adjustment together with
42 its reasons for the adjustment to the commissioner.
43 The report must be submitted not later than the 30th

1 day after the date the adjustment is made.

2 Revised Law

3 Sec. 1506.057. ANNUAL REPORT OF POOL'S ACTIVITIES. (a) Not
4 later than June 1 of each year, the board shall submit a report to
5 the governor, the lieutenant governor, the speaker of the house of
6 representatives, and the commissioner.

7 (b) The report must summarize the activities of the pool in
8 the calendar year preceding the year in which the report is
9 submitted and must include information relating to net written and
10 earned premiums, plan enrollment, administration expenses, and
11 paid and incurred losses. (V.T.I.C. Art. 3.77, Sec. 6(d).)

12 Source Law

13 (d) Not later than June 1 of each year, the board
14 shall make an annual report to the governor, the
15 lieutenant governor, the speaker of the house of
16 representatives, and the commissioner. The report
17 shall summarize the activities of the pool in the
18 preceding calendar year, including information
19 regarding net written and earned premiums, plan
20 enrollment, administration expenses, and paid and
21 incurred losses.

22 Revisor's Note

23 Section 6(d), V.T.I.C. Article 3.77, refers to an
24 "annual report" and requires that it be filed not later
25 than "June 1 of each year." The revised law omits
26 "annual" as unnecessary because the law requires the
27 report to be submitted each year and describes the
28 period to be covered by the report.

29 Revised Law

30 Sec. 1506.058. ADDITIONAL POWERS AND DUTIES. The
31 commissioner by rule may establish powers and duties of the board in
32 addition to those provided by this chapter. (V.T.I.C. Art. 3.77,
33 Sec. 8 (part).)

34 Source Law

35 Sec. 8. The commissioner may by rule establish
36 additional powers and duties of the board and

37 Revisor's Note
38 (End of Subchapter)

39 The revised law omits Section 3, V.T.I.C. Article

1 3.77, relating to the creation of the Texas Health
2 Insurance Risk Pool, as executed. The omitted law
3 reads:

4 Sec. 3. The Texas Health Insurance
5 Risk Pool is created.

6 [Sections 1506.059-1506.100 reserved for expansion]

7 SUBCHAPTER C. POWERS AND DUTIES OF POOL

8 Revised Law

9 Sec. 1506.101. PURPOSES OF POOL. (a) The purposes of the
10 pool are to:

11 (1) provide for access to quality health care at
12 minimum cost to the public;

13 (2) relieve the insurable population of the disruptive
14 cost of sharing coverage; and

15 (3) maximize reliance on strategies of managed care
16 proven by the private sector.

17 (b) The pool is not intended to diminish the availability of
18 traditional health care coverage to consumers who are eligible for
19 that coverage. (V.T.I.C. Art. 3.77, Secs. 1(c), (d).)

20 Source Law

21 (c) To provide for access to quality health care
22 at minimum cost to the public, to relieve the insurable
23 population of the disruptive cost of sharing coverage,
24 and to maximize reliance on strategies of managed care
25 proven by the private sector, the legislature hereby
26 authorizes the Texas Health Insurance Risk Pool.

27 (d) The creation of the Texas Health Insurance
28 Risk Pool is not intended to diminish the availability
29 of traditional health care insurance to consumers who
30 currently are eligible for these policies.

31 Revisor's Note

32 Sections 1(a) and (b), V.T.I.C. Article 3.77,
33 contain legislative findings relating to the lack of
34 availability of health insurance. The revised law
35 omits the findings because they are executed. The
36 omitted law reads:

37 Art. 3.77

38 Sec. 1. (a) The legislature finds
39 that medically uninsurable Texans face
40 critical problems with respect to health
41 care coverage, access to care, job

1 mobility, and family impoverishment arising
2 from their health status.

3 (b) Competitive forces in the
4 marketplaces for health care and health
5 insurance will operate over time to
6 increase the number of medically
7 uninsurable persons.

8 Revised Law

9 Sec. 1506.102. EMPLOYEES; COMMITTEES. (a) The pool may
10 employ and set the compensation of any persons necessary to assist
11 the pool in carrying out its responsibilities and functions.

12 (b) The pool may appoint appropriate legal, actuarial, and
13 other committees necessary to provide technical assistance in
14 operating the pool and performing any of the functions of the pool.
15 (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

16 Source Law

17 (b) As part of its authority, the pool may:

18 . . .
19 (8) appoint appropriate legal, actuarial,
20 and other committees that are necessary to provide
21 technical assistance in operating the pool and
22 performing any of the functions of the pool;

23 (9) employ and set the compensation of any
24 persons necessary to assist the pool in carrying out
25 its responsibilities and functions;

26 . . .

27 Revised Law

28 Sec. 1506.103. PROVIDING COVERAGE. (a) The pool may
29 provide health benefit coverage to an individual who is eligible
30 for that coverage under this chapter.

31 (b) The pool may issue health benefit coverage subject to
32 this chapter and the pool's plan of operation under Section
33 1506.201.

34 (c) The pool may issue additional types of health benefit
35 coverage to provide optional coverages that comply with applicable
36 provisions of state and federal law, including a Medicare
37 supplement benefit plan. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

38 Source Law

39 (b) As part of its authority, the pool may:

40 (1) provide health benefits coverage to
41 persons who are eligible for that coverage under this
42 article;

43 . . .
44 (7) issue insurance policies subject to
45 this article and the plan of operation;

1 . . .
2 (13) issue additional types of health
3 insurance policies to provide optional coverages which
4 comply with applicable provisions of state and federal
5 law, including Medicare supplemental health
6 insurance;
7 . . .

8 Revisor's Note

9 Section 6(b)(13), V.T.I.C. Article 3.77, refers
10 to "Medicare supplemental health insurance." The
11 revised law substitutes "Medicare supplement benefit
12 plan" because V.T.I.C. Article 3.77, revised as this
13 chapter, applies to evidences of coverage issued by
14 health maintenance organizations to supplement
15 reimbursements under Medicare. Health maintenance
16 organizations provide health benefit coverage, but the
17 organizations are not insurers. Consequently,
18 "benefit plan" is a more accurate term than
19 "insurance." The substitution of "benefit plan" in
20 this context, as well as any comparable change
21 necessary to ensure consistency in terminology, is
22 made throughout this chapter.

23 Revised Law

24 Sec. 1506.104. CHARGES, FORMULAS, AND FORMS. (a) The pool
25 may establish appropriate rates, rate schedules, rate adjustments,
26 expense allowances, agents' referral fees, and claim reserve
27 formulas and perform actuarial functions appropriate to the
28 operation of the pool.

29 (b) The pool may adopt policy forms, endorsements, and
30 riders and applications for coverage. (V.T.I.C. Art. 3.77, Sec.
31 6(b) (part).)

32 Source Law

33 (b) As part of its authority, the pool may:

34 . . .
35 (5) establish appropriate rates, rate
36 schedules, rate adjustments, expense allowances,
37 agents' referral fees, and claim reserve formulas and
38 perform any actuarial functions appropriate to the
39 operation of the pool;

40 (6) adopt policy forms, endorsements, and
41 riders and applications for coverage;
42 . . .

1 Revised Law

2 Sec. 1506.105. PREMIUM RATES. (a) The pool may not charge
3 premium rates that are unreasonable in relation to the benefits
4 provided, the risk experience, and the reasonable expenses of
5 providing the coverage.

6 (b) Separate schedules of premium rates based on age, sex,
7 and geographic location may apply for individual risks.

8 (c) Premium rates and premium rate schedules may be adjusted
9 for appropriate risk factors, including age and variation in claim
10 costs. The pool may consider appropriate risk factors in
11 accordance with established actuarial and underwriting practices.

12 (d) The pool shall establish the standard risk rate. In
13 establishing the rate, the pool shall use reasonable actuarial
14 techniques and consider the premium rates charged by other health
15 benefit plan issuers offering health benefit coverage to
16 individuals. The rate must reflect anticipated experience and
17 expenses for health benefit coverage.

18 (e) Initial pool premium rates may not be less than 125
19 percent or greater than 150 percent of rates established as
20 applicable for individual standard rates. Subsequent premium rates
21 shall be established to provide fully for all of the expected costs
22 of claims, including recovery of prior losses, expenses of
23 operation, investment income from claim reserves, and any other
24 cost factors, subject to the limitations described in this
25 subsection. In no event may pool premium rates exceed 200 percent
26 of rates applicable to individual standard risks.

27 (f) The pool shall submit each rate and rate schedule to the
28 commissioner for approval. The pool may not use a rate or rate
29 schedule before the rate or schedule is approved by the
30 commissioner. In evaluating a rate or rate schedule of the pool,
31 the commissioner shall consider the factors provided by this
32 section. (V.T.I.C. Art. 3.77, Sec. 9.)

33 Source Law

34 Sec. 9. (a) Rates charged by the pool may not

1 be unreasonable in relation to the coverage provided
2 and the risk experience and expenses of providing the
3 coverage.

4 (b) Rates and rate schedules may be adjusted for
5 appropriate risk factors including age and variation
6 in claim costs, and the board may consider appropriate
7 risk factors in accordance with established actuarial
8 and underwriting practices.

9 (c) Premiums charged for pool coverage may not
10 be unreasonable in relation to the benefits provided,
11 the risk experience, and the reasonable expenses of
12 providing the coverage. Separate schedules of premium
13 rates based on age, sex, and geographic location may
14 apply for individual risks.

15 (d) The pool shall determine the standard risk
16 rate by considering the premium rates charged by other
17 insurers offering health insurance coverage to
18 individuals. The standard risk rate shall be
19 established using reasonable actuarial techniques,
20 and shall reflect anticipated experience and expenses
21 for such coverage. Initial pool rates may not be less
22 than 125 percent and may not exceed 150 percent of
23 rates established as applicable for individual
24 standard rates. Subsequent rates shall be established
25 to provide fully for the expected costs of claims
26 including recovery of prior losses, expenses of
27 operation, investment income of claim reserves, and
28 any other cost factors subject to the limitations
29 described in this subsection. In no event shall pool
30 rates exceed 200 percent of rates applicable to
31 individual standard risks.

32 (e) All rates and rate schedules shall be
33 submitted to the commissioner for approval, and the
34 commissioner must approve the rates and rate schedules
35 of the pool before they are used by the pool. The
36 commissioner in evaluating the rates and rate
37 schedules of the pool shall consider the factors
38 provided by this section.

39 Revised Law

40 Sec. 1506.106. REINSURANCE. The pool may provide for
41 reinsurance on a facultative or treaty basis or on both facultative
42 and treaty bases. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

43 Source Law

44 (b) As part of its authority, the pool may:

45 . . .
46 (16) provide for reinsurance on either a
47 facultative or treaty basis or both.

48 Revised Law

49 Sec. 1506.107. CONTRACTS. (a) The pool may enter into a
50 contract that is necessary to carry out this chapter, including,
51 with the approval of the commissioner, a contract with:

52 (1) a similar pool in another state for the joint
53 performance of common administrative functions; or

54 (2) another organization for the performance of

1 administrative functions.

2 (b) The pool may contract for stop-loss insurance for risks
3 incurred by the pool. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

4 Source Law

5 (b) As part of its authority, the pool may:

6 . . .
7 (2) enter into contracts that are
8 necessary to carry out this article including, with
9 the approval of the commissioner, entering into
10 contracts with similar pools in other states for the
11 joint performance of common administrative functions
12 or with other organizations for the performance of
13 administrative functions;

14 . . .
15 (10) contract for stop-loss insurance for
16 risks incurred by the pool;
17 . . .

18 Revised Law

19 Sec. 1506.108. LEGAL ACTION. (a) The pool may sue or be
20 sued.

21 (b) The pool may take any legal action necessary to:

22 (1) avoid payment of improper claims against the pool
23 or the coverage provided by or through the pool; or

24 (2) recover or collect amounts due the pool,
25 including:

26 (A) assessments due the pool;

27 (B) amounts erroneously or improperly paid by the
28 pool; and

29 (C) amounts paid by the pool as a mistake of fact
30 or law. (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

31 Source Law

32 (b) As part of its authority, the pool may:

33 . . .
34 (3) sue or be sued, including taking any
35 legal actions necessary or proper to recover or
36 collect assessments due the pool;

37 (4) institute any legal action necessary
38 to avoid payment of improper claims against the pool or
39 the coverage provided by or through the pool, to
40 recover any amounts erroneously or improperly paid by
41 the pool, to recover any amounts paid by the pool as a
42 mistake of fact or law, and to recover other amounts
43 due the pool;
44 . . .

45 Revised Law

46 Sec. 1506.109. COST CONTAINMENT. (a) The pool may provide

1 for and use cost containment measures and requirements, including
2 preadmission screening, the requirement of a second surgical
3 opinion, concurrent utilization review subject to Article 21.58A,
4 and individual case management, to make the coverage offered by the
5 pool more cost-effective.

6 (b) The pool may design, use, contract for, or otherwise
7 arrange for the delivery of cost-effective health care services,
8 including establishing or contracting with preferred provider
9 organizations and health maintenance organizations. (V.T.I.C.
10 Art. 3.77, Secs. 2(1), 6(b) (part).)

11 Source Law

12 Sec. 2. In this article:

13 (1) "Benefits plan" means coverage to be
14 offered by the pool to eligible persons under Section
15 11 of this article.

16 [Sec. 6]

17 (b) As part of its authority, the pool may:

18 . . .
19 (14) provide for and employ cost
20 containment measures and requirements including, but
21 not limited to, preadmission screening, second
22 surgical opinion, concurrent utilization review
23 subject to Article 21.58A of this code, and individual
24 case management for the purpose of making the benefit
25 plans more cost effective;

26 (15) design, utilize, contract, or
27 otherwise arrange for the delivery of cost-effective
28 health care services, including establishing or
29 contracting with preferred provider organizations and
30 health maintenance organizations; and
31 . . .

32 Revisor's Note

33 Section 6(b)(14), V.T.I.C. Article 3.77,
34 contains a list of cost containment measures,
35 "including, but not limited to," certain specified
36 items. The phrase "but not limited to" is omitted from
37 the revised law for the reason stated in Revisor's Note
38 (4) to Section 1506.001.

39 Revised Law

40 Sec. 1506.110. BORROWING. The pool may borrow money as
41 necessary to implement the purposes of the pool. (V.T.I.C. Art.
42 3.77, Sec. 6(b) (part).)

1 Source Law

2 (b) As part of its authority, the pool may:

3 . . .
4 (12) borrow money as necessary to
5 implement the purposes of the pool;
6 . . .

7 Revised Law

8 Sec. 1506.111. ADDITIONAL AUTHORITY. In addition to the
9 other powers granted to the pool under this chapter, the pool may
10 exercise any of the authority that a health benefit plan issuer
11 authorized to write health benefit plans in this state may exercise
12 under the law of this state. (V.T.I.C. Art. 3.77, Sec. 6(a).)

13 Source Law

14 Sec. 6. (a) The pool may exercise any of the
15 authority that an insurance company authorized to
16 write health insurance in this state may exercise
17 under the law of this state.

18 [Sections 1506.112-1506.150 reserved for expansion]

19 SUBCHAPTER D. POOL COVERAGE AND BENEFITS

20 Revised Law

21 Sec. 1506.151. MINIMUM POOL COVERAGE. (a) The pool shall
22 offer coverage consistent with major medical expense coverage to
23 each eligible individual who is not eligible for Medicare.

24 (b) The board, with the approval of the commissioner, shall
25 establish:

- 26 (1) the coverages to be provided by the pool;
27 (2) the applicable schedules of benefits; and
28 (3) any exclusions to coverage and other limitations.

29 (c) The benefits provisions of the pool's coverage must
30 include:

- 31 (1) all required or applicable definitions;
32 (2) a description of covered services required under
33 the pool;
34 (3) a list of any exclusions or limitations to
35 coverage; and
36 (4) the deductibles, coinsurance options, and
37 copayment options that are required or permitted. (V.T.I.C. Art.
38 3.77, Secs. 11(a), (b).)

1 Source Law

2 Sec. 11. (a) The pool shall offer pool
3 coverage consistent with major medical expense
4 coverage to each eligible person who is not eligible
5 for Medicare. The board, with the approval of the
6 commissioner, shall establish:

- 7 (1) the coverages to be provided by the
8 pool;
9 (2) the applicable schedules of benefits;
10 and
11 (3) any exclusions to coverage and other
12 limitations.

13 (b) The benefits provisions of the pool's health
14 benefits coverages must include the following:

- 15 (1) all required or applicable
16 definitions;
17 (2) a list of any exclusions or
18 limitations to coverage;
19 (3) a description of covered services
20 required under the pool; and
21 (4) the deductibles, coinsurance options,
22 and copayment options that are required or permitted
23 under the pool.

24 Revised Law

25 Sec. 1506.152. ELIGIBILITY FOR COVERAGE. (a) An
26 individual who is a legally domiciled resident of this state is
27 eligible for coverage from the pool if the individual:

28 (1) provides to the pool evidence that the individual
29 maintained health benefit plan coverage for the preceding 18 months
30 with no gap in coverage longer than 63 days and with the most recent
31 coverage being provided through an employer-sponsored plan, church
32 plan, or government plan;

33 (2) provides to the pool evidence that the individual
34 maintained health benefit plan coverage under another state's
35 qualified Health Insurance Portability and Accountability Act
36 health program that was terminated because the individual did not
37 reside in that state and submits an application for pool coverage
38 not later than the 63rd day after the date the coverage described by
39 this subdivision was terminated; or

40 (3) has been a legally domiciled resident of this
41 state for the preceding 30 days, is a citizen of the United States
42 or has been a permanent resident of the United States for at least
43 three continuous years, and provides to the pool:

44 (A) a notice of rejection of, or refusal to

1 issue, substantially similar individual health benefit plan
2 coverage from a health benefit plan issuer, other than an insurer
3 that offers only stop-loss, excess loss, or reinsurance coverage,
4 if the rejection or refusal was for health reasons;

5 (B) certification from an agent or salaried
6 representative of a health benefit plan issuer that states that the
7 agent or salaried representative cannot obtain substantially
8 similar individual coverage for the individual from any health
9 benefit plan issuer that the agent or salaried representative
10 represents because, under the underwriting guidelines of the health
11 benefit plan issuer, the individual will be denied coverage as a
12 result of a medical condition of the individual;

13 (C) an offer to issue substantially similar
14 individual coverage only with conditional riders;

15 (D) a notice of refusal by a health benefit plan
16 issuer to issue substantially similar individual coverage except at
17 a rate exceeding the pool rate; or

18 (E) a diagnosis of the individual with one of the
19 medical or health conditions on the list adopted under Section
20 1506.154.

21 (b) Each dependent of an individual who is eligible for
22 coverage from the pool is also eligible for coverage from the pool.

23 (c) If an individual who obtains coverage from the pool
24 under Subsection (a) is a child, each parent, grandparent,
25 brother, sister, or child of that individual who resides with that
26 individual is also eligible for coverage from the pool.

27 (d) The board shall develop a form to be used for
28 certification under Subsection (a)(3)(B). Before it may be used,
29 the form must be approved by the commissioner. (V.T.I.C. Art. 3.77,
30 Secs. 2(6), (17), 10(a), (b), (c).)

31 Source Law

32 [Sec. 2]

33 (6) "Family member" means a parent,
34 grandparent, brother, sister, or child of a dependent
35 residing with the insured.

1 (17) "Resident" means:

2 (A) an individual who has been
3 legally domiciled in Texas for a minimum of 30 days for
4 persons eligible for enrollment in the pool under
5 Section 10(b) of this article; or

6 (B) an individual who is legally
7 domiciled in Texas for persons eligible for enrollment
8 in the pool under Section 10(a) of this article.

9 Sec. 10. (a) An individual who is a resident,
10 as defined by Section 2(17)(B) of this article, and who
11 continues to be a resident, is eligible for coverage
12 from the pool if the individual:

13 (1) provides to the pool evidence that the
14 individual has maintained health insurance coverage
15 for the previous 18 months, with no gap in coverage
16 greater than 63 days, of which the most recent coverage
17 was through an employer-sponsored plan, church plan,
18 or government plan; or

19 (2) provides to the pool evidence that the
20 individual had health insurance coverage under another
21 state's qualified Health Insurance Portability and
22 Accountability Act health program that was terminated
23 because the individual did not reside in that state and
24 submits an application for pool coverage not later
25 than the 63rd day after the date that coverage was
26 terminated.

27 (b) Any individual who is and continues to be a
28 resident, as defined by Section 2(17)(A) of this
29 article, and who is a citizen of the United States or
30 has been a permanent resident of the United States for
31 at least three continuous years is eligible for
32 coverage from the pool if the individual provides to
33 the pool:

34 (1) a notice of rejection or refusal to
35 issue substantially similar individual insurance for
36 health reasons by one insurer, other than a rejection
37 or refusal by an insurer offering only stop-loss,
38 excess loss, or reinsurance coverage;

39 (2) a certification from an agent or
40 salaried representative of an insurer, on a form
41 developed by the board and approved by the
42 commissioner, that states that the agent or salaried
43 representative is unable to obtain substantially
44 similar individual insurance for the individual with
45 any state-licensed insurer that the agent or salaried
46 representative represents because the individual will
47 be declined for coverage as a result of a medical
48 condition of the individual under the underwriting
49 guidelines of the insurer;

50 (3) an offer to issue substantially
51 similar individual insurance only with conditional
52 riders;

53 (4) a refusal by an insurer to issue
54 substantially similar individual insurance except at a
55 rate exceeding the pool rate; or

56 (5) diagnosis of the individual with one
57 of the medical or health conditions listed by the board
58 under Section 6(c) of this article and for which a
59 person shall be eligible for pool coverage.

60 (c) Each dependent of a person who is eligible
61 for coverage from the pool shall also be eligible for
62 coverage from the pool. In the instance of a child who
63 is the primary insured, resident family members shall
64 also be eligible for coverage.

1 Revisor's Note

2 (1) Section 10, V.T.I.C. Article 3.77, refers to
3 an individual who is a resident and "continues to be a
4 resident." The revised law omits the quoted language
5 as unnecessary because an individual is a resident
6 only as long as the individual continues to be a
7 resident. Also, Section 10(f), V.T.I.C. Article 3.77,
8 revised as Section 1506.158, expressly states that an
9 individual's pool coverage generally ends on the date
10 the individual ceases to be a resident.

11 (2) Section 10(b)(2), V.T.I.C. Article 3.77,
12 refers to a "state-licensed insurer." "State-licensed
13 insurer" refers to any foreign or domestic entity that
14 has authority from the Texas Department of Insurance
15 to engage in insurance business in this state and is
16 equivalent to "insurer," as defined by Section 2(11),
17 V.T.I.C. Article 3.77. The revised law substitutes
18 "health benefit plan issuer" for "state-licensed
19 insurer" for the reason stated in Revisor's Note (3) to
20 Section 1506.001.

21 Revised Law

22 Sec. 1506.153. INELIGIBILITY FOR COVERAGE.
23 Notwithstanding Section 1506.152, an individual is not eligible for
24 coverage from the pool if:

25 (1) on the date pool coverage is to take effect, the
26 individual has health benefit plan coverage from a health benefit
27 plan issuer or health benefit arrangement in effect;

28 (2) at the time the individual applies to the pool, the
29 individual is eligible for other health care benefits, including
30 benefits from the continuation of coverage under Title X,
31 Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C.
32 Section 1161 et seq.), as amended (COBRA), other than:

33 (A) coverage, including COBRA or other
34 continuation coverage or conversion coverage, maintained for any

1 preexisting condition waiting period under a pool policy;

2 (B) employer group coverage conditioned by a
3 limitation of the kind described by Section 1506.152(a)(3)(A) or
4 (C); or

5 (C) individual coverage conditioned by a
6 limitation described by Section 1506.152(a)(3)(C) or (D);

7 (3) within 12 months before the date the individual
8 applies to the pool, the individual terminated coverage in the
9 pool, unless the individual demonstrates a good faith reason for
10 the termination;

11 (4) the individual is confined in a county jail or
12 imprisoned in a state prison;

13 (5) any of the individual's premiums are paid for or
14 reimbursed under a government-sponsored program or by a government
15 agency or health care provider, other than as an otherwise
16 qualifying full-time employee of a government agency or health care
17 provider or as a dependent of such an employee;

18 (6) the individual's prior coverage with the pool was
19 terminated:

20 (A) during the 12-month period preceding the date
21 of application for nonpayment of premiums; or

22 (B) for fraud; or

23 (7) the individual is eligible for health benefit plan
24 coverage provided in connection with a policy, plan, or program
25 paid for or sponsored by an employer, even though the employer
26 coverage is declined. (V.T.I.C. Art. 3.77, Secs. 10(e), (h)
27 (part).)

28 Source Law

29 (e) A person is not eligible for coverage from
30 the pool if the person:

31 (1) has in effect on the date pool coverage
32 takes effect health insurance coverage from an insurer
33 or insurance arrangement;

34 (2) is eligible for other health care
35 benefits at the time application is made to the pool,
36 including COBRA continuation, except:

37 (A) coverage, including COBRA
38 continuation, other continuation or conversion
39 coverage, maintained for the period of time the person

1 is satisfying any pre-existing condition waiting
2 period under a pool policy; or

3 (B) employer group coverage
4 conditioned by the type of limitations described by
5 Subsections (b)(1) or (3) of this section; or

6 (C) individual coverage conditioned
7 by the limitations described by Subsections (b)(3) or
8 (4) of this section;

9 (3) has terminated coverage in the pool
10 within 12 months of the date that application is made
11 to the pool, unless the person demonstrates a good
12 faith reason for the termination;

13 (4) is confined in a county jail or
14 imprisoned in a state prison;

15 (5) has premiums that are paid for or
16 reimbursed under any government sponsored program or
17 by any government agency or health care provider,
18 except as an otherwise qualifying full-time employee,
19 or dependent thereof, of a government agency or health
20 care provider;

21 (6) has had prior coverage with the pool
22 terminated during the 12 months immediately preceding
23 the date of application for nonpayment of premiums; or

24 (7) has had prior coverage with the pool
25 terminated for fraud.

26 (h) A person who is eligible for health
27 insurance benefits provided in connection with a
28 policy, plan, or program paid for or sponsored by an
29 employer, even though the employer coverage is
30 declined, is not eligible for pool coverage. . . .

31 Revisor's Note

32 Section 10(e), V.T.I.C. Article 3.77, makes
33 several references to COBRA continuation of health
34 care coverage. While COBRA is an acronym that is used
35 with some frequency, for clarity the revised law adds
36 the name of the federal statute, the Consolidated
37 Omnibus Budget Reconciliation Act of 1985, and its
38 citation at the first reference to COBRA.

39 Revised Law

40 Sec. 1506.154. LIST OF COVERED CONDITIONS. (a) The board
41 shall adopt a list of medical or health conditions for which an
42 individual is eligible for pool coverage under Section
43 1506.152(a)(3)(E) without applying for health benefit plan
44 coverage.

45 (b) The board may amend the list as appropriate. (V.T.I.C.
46 Art. 3.77, Sec. 6(c) (part).)

47 Source Law

48 (c) The board shall promulgate a list of medical
49 or health conditions for which a person shall be

1 eligible for pool coverage without applying for health
2 insurance. The list . . . may be amended from time to
3 time as may be appropriate.

4 Revisor's Note

5 (1) Section 6(c), V.T.I.C. Article 3.77,
6 provides that the board may amend the list of
7 conditions required by that section "from time to
8 time." The revised law omits the quoted language as
9 unnecessary because the power to take an action
10 includes the power to act "from time to time."

11 (2) The part of Section 6(c), V.T.I.C. Article
12 3.77, that relates to the date on which the initial
13 list of conditions became effective is omitted from
14 the revised law as executed. The omitted law reads:

15 (c) . . . [The list] shall be
16 effective on the first day of the operation
17 of the pool and

18 Revised Law

19 Sec. 1506.155. PREEXISTING CONDITIONS. (a) Except as
20 provided by this section and Section 1506.056, pool coverage
21 excludes charges or expenses incurred before the first anniversary
22 of the effective date of coverage with regard to any condition for
23 which medical advice, care, or treatment was recommended or
24 received during the six-month period preceding the effective date
25 of coverage.

26 (b) The exclusion provided by Subsection (a) does not apply
27 to an individual who:

28 (1) was continuously covered for a period of at least
29 12 months, excluding any waiting period, by health benefit plan
30 coverage that terminated not earlier than the 63rd day before the
31 effective date of coverage under the pool; and

32 (2) applied for pool coverage not later than the 63rd
33 day after the date the health benefit plan coverage described by
34 Subdivision (1) terminated.

35 (c) If an individual was covered by health benefit plan
36 coverage that was in effect at any time during the 12-month period

1 preceding the effective date of the individual's coverage under the
2 pool, the pool shall subtract from the exclusion period required
3 under Subsection (a) the period that the individual was covered
4 under that health benefit plan and any waiting period that applied
5 before that health benefit plan coverage became effective.
6 (V.T.I.C. Art. 3.77, Sec. 12.)

7 Source Law

8 Sec. 12. (a) Except as provided by this
9 section and Section 11(c) of this article, pool
10 coverage shall exclude charges or expenses incurred
11 during the first 12 months following the effective
12 date of coverage with regard to any condition for which
13 medical advice, care, or treatment was recommended or
14 received during the six-month period preceding the
15 effective date of coverage.

16 (b) A preexisting condition provision shall not
17 apply to an individual who was continuously covered
18 for an aggregate period of 12 months by health
19 insurance that was in effect up to a date not more than
20 63 days before the effective date of coverage under the
21 pool, excluding any waiting period, provided that the
22 application for pool coverage is made no later than 63
23 days following the termination of coverage.

24 (c) In determining whether a preexisting
25 condition provision applies to an individual covered
26 by the pool, the pool shall credit the time the
27 individual was previously covered under health
28 insurance if the previous coverage was in effect at any
29 time during the 12 months preceding the effective date
30 of coverage under the pool. Any waiting period that
31 applied before that coverage became effective also
32 shall be credited against the preexisting condition
33 provision period.

34 Revised Law

35 Sec. 1506.156. BENEFIT REDUCTION. The pool shall reduce
36 benefits otherwise payable under pool coverage by:

37 (1) the total amount paid or payable through any other
38 health benefit plan or health benefit arrangement; and

39 (2) the total amount of hospital or medical expense
40 benefits paid or payable under:

41 (A) workers' compensation coverage;

42 (B) automobile insurance, regardless of whether
43 provided on the basis of fault or no fault; or

44 (C) a state or federal law or program. (V.T.I.C.
45 Art. 3.77, Sec. 11(d).)

1 Source Law

2 (d) Benefits otherwise payable under pool
3 coverage shall be reduced by amounts paid or payable
4 through any other health insurance, or insurance
5 arrangement, and by all hospital and medical expense
6 benefits paid or payable under any workers'
7 compensation coverage, automobile insurance whether
8 provided on the basis of fault or no-fault, and by any
9 hospital or medical benefits paid or payable under or
10 provided pursuant to any state or federal law or
11 program.

12 Revised Law

13 Sec. 1506.157. RECOVERY OF CERTAIN AMOUNTS. (a) The pool
14 has a cause of action against an eligible individual for the
15 recovery of the amount of benefits paid that are not for covered
16 expenses.

17 (b) Benefits due from the pool may be reduced or refused as
18 an offset against an amount recoverable under this section.
19 (V.T.I.C. Art. 3.77, Sec. 11(e).)

20 Source Law

21 (e) The pool has a cause of action against an
22 eligible person for the recovery of the amount of
23 benefits paid that are not for covered expenses.
24 Benefits due from the pool may be reduced or refused as
25 an offset against any amount recoverable under this
26 subsection.

27 Revised Law

28 Sec. 1506.158. TERMINATION OF POOL COVERAGE. (a) An
29 individual's pool coverage ends:

30 (1) on the date the individual ceases to be a legally
31 domiciled resident of this state, unless the individual:

32 (A) is a student younger than 25 years of age and
33 is financially dependent on the parent;

34 (B) is a child for whom an individual may be
35 obligated to pay child support; or

36 (C) is a child who is disabled and dependent on
37 the parent, regardless of the age of the child;

38 (2) on the date the individual requests coverage to
39 end;

40 (3) on the date the individual covered by the pool
41 dies;

1 (4) on the date state law requires cancellation of the
2 coverage;

3 (5) at the option of the pool, on the 31st day after
4 the date the pool sends to the individual any inquiry concerning the
5 individual's eligibility, including an inquiry concerning the
6 individual's residence, to which the individual does not reply;

7 (6) on the 31st day after the date a premium payment
8 for pool coverage becomes due if the payment is not made before that
9 day; or

10 (7) at the time the individual ceases to meet the
11 eligibility requirements for coverage.

12 (b) Notwithstanding Subsection (a), the coverage of an
13 individual who ceases to meet the eligibility requirements for
14 coverage terminates on the earlier of:

15 (1) the first premium due date after the date the pool
16 determines the individual does not meet the eligibility
17 requirements; or

18 (2) the first day of the first month after the month in
19 which the pool determines the individual does not meet the
20 eligibility requirements.

21 (c) The pool has the sole discretion to determine that an
22 individual does not meet the eligibility requirements for coverage.

23 (d) An individual may maintain pool coverage for the period
24 the individual is satisfying a preexisting waiting period under
25 another health benefit plan or health benefit arrangement intended
26 to replace the pool coverage. (V.T.I.C. Art. 3.77, Secs. 10(d),
27 (f), (g).)

28 Source Law

29 (d) A person may maintain pool coverage for the
30 period of time the person is satisfying a preexisting
31 waiting period under another health insurance policy
32 or insurance arrangement intended to replace the pool
33 policy.

34 (f) Pool coverage shall cease:

35 (1) on the date a person is no longer a
36 resident of this state, except for a child who is a
37 student under 25 years of age and who is financially
38 dependent upon the parent, a child for whom a person

1 may be obligated to pay child support, or a child of
2 any age who is disabled and dependent upon the parent;

3 (2) on the date a person requests coverage
4 to end;

5 (3) upon the death of the covered person;

6 (4) on the date state law requires
7 cancellation of the policy;

8 (5) at the option of the pool, 30 days
9 after the pool sends to the person any inquiry
10 concerning the person's eligibility, including an
11 inquiry concerning the person's residence, to which
12 the person does not reply;

13 (6) on the 31st day after the day on which
14 a premium payment for pool coverage becomes due if the
15 payment is not made before that date; or

16 (7) at such time as the person ceases to
17 meet the eligibility requirements of this section.

18 (g) Coverage of a person who ceases to meet the
19 eligibility requirements of this section shall be
20 terminated on the earlier of the premium due date that
21 follows the date the pool determines the person does
22 not meet the eligibility requirements or the first day
23 of the month that follows the month in which the pool
24 determines the person does not meet the eligibility
25 requirements. The pool has the sole discretion to
26 determine that a person does not meet the eligibility
27 requirements.

28 Revisor's Note

29 Section 10(f)(1), V.T.I.C. Article 3.77, refers
30 to a person who ceases to be "a resident of this
31 state." Section 2(17), V.T.I.C. Article 3.77,
32 provides the definition of "resident" for the purposes
33 of that article, and that provision is revised in
34 Section 1506.152. Under that provision, to qualify as
35 a resident under V.T.I.C. Article 3.77 an individual
36 must be legally domiciled in this state. The revised
37 law in this section is drafted accordingly.

38 Revised Law

39 Sec. 1506.159. PROHIBITION ON ARRANGEMENT OR ATTEMPTED
40 ARRANGEMENT OF CERTAIN POOL COVERAGE; PENALTY. (a) A health
41 benefit plan issuer, agent, third-party administrator, or other
42 person authorized or licensed under this code may not arrange or
43 assist in, or attempt to arrange or assist in, the application for
44 coverage from or placement in the pool of an individual who is not
45 eligible under Section 1506.153(7) for coverage from the pool for
46 the purpose of separating the person from health benefit plan
47 coverage offered or provided in connection with employment that

1 would be available to the person as an employee or a dependent of an
2 employee.

3 (b) A violation of this section is an unfair method of
4 competition and an unfair or deceptive act or practice under
5 Chapter 541. (V.T.I.C. Art. 3.77, Sec. 10(h) (part).)

6 Source Law

7 (h) . . . An insurer, agent, third party
8 administrator, or other person licensed under this
9 code may not arrange or assist in or attempt to arrange
10 or assist in the application for pool coverage by, or
11 placement in the pool of a person who is ineligible
12 under this subsection for the purpose of separating
13 the person from health insurance benefits offered or
14 provided in connection with employment that would be
15 available to the person as an employee or dependent of
16 an employee. A violation of this section is an unfair
17 method of competition and an unfair or deceptive act or
18 practice under Article 21.21 of this code.

19 Revisor's Note

20 Section 10(h), V.T.I.C. Article 3.77, refers to
21 certain persons "licensed under this code." For
22 consistency with other provisions of this code and
23 because some of the persons listed would hold a
24 certificate of authority under this code, the revised
25 law refers to persons "authorized or licensed" under
26 this code.

27 [Sections 1506.160-1506.200 reserved for expansion]

28 SUBCHAPTER E. OPERATION OF POOL

29 Revised Law

30 Sec. 1506.201. PLAN OF OPERATION. (a) Operation and
31 management of the pool is governed by a plan of operation. The plan
32 of operation includes the articles, bylaws, and operating rules of
33 the pool that are adopted by the board.

34 (b) The plan of operation must ensure the fair, reasonable,
35 and equitable administration of the pool.

36 (c) In addition to complying with the other requirements of
37 this chapter, the plan of operation must include procedures for:

38 (1) operation of the pool;

39 (2) selection of an administrator as provided by

1 Section 1506.202;

2 (3) creation of a fund, under management of the board,
3 for administrative expenses;

4 (4) handling, accounting, and auditing of money and
5 other assets of the pool;

6 (5) development and implementation of a program to:

7 (A) publicize the existence of the pool, the
8 eligibility requirements for coverage under the pool, and
9 enrollment procedures; and

10 (B) foster public awareness of the pool;

11 (6) creation of a grievance committee to review
12 complaints presented by applicants for coverage from the pool and
13 individuals who are covered by the pool; and

14 (7) other matters as may be necessary and proper for
15 the execution of the board's powers, duties, and obligations under
16 this chapter.

17 (d) The board shall amend the plan of operation as necessary
18 to carry out this chapter. An amendment to the plan of operation
19 must be approved by the commissioner before it becomes a part of the
20 plan. (V.T.I.C. Art. 3.77, Secs. 2(15), 5(a) (part), (b), (f).)

21 Source Law

22 [Sec. 2]

23 (15) "Plan of operation" means the plan of
24 operation of the pool and includes the articles,
25 bylaws, and operating rules of the pool that are
26 adopted by the board under Section 5 of this article.

27 Sec. 5. (a) . . . a plan of operation for the
28 pool that will assure the fair, reasonable, and
29 equitable administration of the pool.

30 (b) In addition to the other requirements of
31 this article, the plan of operation must include
32 procedures for:

33 (1) operation of the pool;

34 (2) selecting an administrator as provided
35 under Section 7 of this article;

36 (3) creating a fund, under management of
37 the board, for administrative expenses;

38 (4) handling, accounting, and auditing of
39 money and other assets of the pool;

40 (5) developing and implementing a program
41 to publicize the existence of the pool, the
42 eligibility requirements for coverage under the pool,
43 enrollment procedures, and to foster public awareness
44 of the plan;

45 (6) creation of a grievance committee to

1 review complaints presented by applicants for coverage
2 from the pool and insureds who receive coverage from
3 the pool; and

4 (7) other matters as may be necessary and
5 proper for the execution of the board's powers, duties,
6 and obligations under this article.

7 (f) The board shall amend the plan of operation
8 as necessary to carry out this article. Amendments to
9 the plan of operation must be approved by the
10 commissioner before they become part of the plan.

11 Revisor's Note

12 Section 5(a), in part, and Sections 5(c), (d),
13 and (e), V.T.I.C. Article 3.77, relate to the initial
14 adoption of the plan of operation for the pool. Those
15 provisions are omitted from the revised law as
16 executed. The omitted law reads:

17 Sec. 5. (a) The pool's initial board
18 shall submit to the commissioner [a plan of
19 operation for the pool]

20 (c) After notice and hearing, the
21 commissioner shall approve the plan of
22 operation if it is determined that the plan
23 is suitable to assure the fair, reasonable,
24 and equitable administration of the pool.

25 (d) The plan of operation takes
26 effect on the date it is approved by
27 commissioner order.

28 (e) If the initial board fails to
29 submit a suitable plan of operation before
30 the 180th day following the appointment of
31 the initial board, the commissioner, after
32 notice and hearing, may adopt all necessary
33 and reasonable rules to provide a plan for
34 the pool. The rules adopted under this
35 subsection shall continue in effect until
36 the initial board submits, and the
37 commissioner approves, a plan of operation
38 under this section.

39 Revised Law

40 Sec. 1506.202. POOL ADMINISTRATOR. (a) The board may
41 select one or more health benefit plan issuers or a third-party
42 administrator authorized by the department to administer the pool.
43 The selection must be made under a competitive bidding process in
44 accordance with the plan of operation.

45 (b) The board shall establish criteria for evaluating the
46 bids submitted under this section. The criteria must include:

47 (1) the bidder's proven ability to handle individual
48 health benefit plans;

1 (2) the bidder's efficiency of claims paying
2 procedures;

3 (3) an estimate of total charges for administering the
4 pool;

5 (4) the bidder's ability to administer the pool in a
6 cost-efficient manner; and

7 (5) the bidder's financial condition and stability.
8 (V.T.I.C. Art. 3.77, Secs. 7(a), (b).)

9 Source Law

10 Sec. 7. (a) After completing a competitive
11 bidding process as provided by the plan of operation,
12 the board may select one or more insurers or a third
13 party administrator certified by the department to
14 administer the pool.

15 (b) The board shall establish criteria for
16 evaluating the bids submitted. The criteria must
17 include:

18 (1) an insurer's or third party
19 administrator's proven ability to handle individual
20 accident and health insurance;

21 (2) the efficiency of an insurer's or third
22 party administrator's claims paying procedures;

23 (3) an estimate of total charges for
24 administering the pool;

25 (4) an insurer's or third party
26 administrator's ability to administer the pool in a
27 cost-efficient manner; and

28 (5) the financial condition and stability
29 of the insurer or third party administrator.

30 Revisor's Note

31 Section 7(a), V.T.I.C. Article 3.77, refers to
32 certain persons "certified" to administer the pool.
33 For consistency with other provisions of this code,
34 the revised law substitutes "authorized" for
35 "certified."

36 Revised Law

37 Sec. 1506.203. ADMINISTRATOR'S TERM; SUCCEEDING TERM. (a)
38 A person selected as a pool administrator serves in that capacity
39 for a three-year term beginning on the date the board issues its
40 order making the selection.

41 (b) Not later than one year before the expiration of a pool
42 administrator's term, the board shall invite all health benefit
43 plan issuers, including the pool administrator, to submit bids to

1 serve as a pool administrator for the succeeding administration
2 period. The selection of the succeeding pool administrator must be
3 made not later than the sixth calendar month preceding the month in
4 which the pool administrator's term expires. (V.T.I.C. Art. 3.77,
5 Secs. 7(c), (d).)

6 Source Law

7 (c) An insurer or third party administrator
8 selected as an administering insurer or third party
9 administrator to administer the pool under this
10 section shall serve for a term of three years from the
11 date on which the board issues its order formally
12 making the selection.

13 (d) Not later than one year before the
14 expiration of an administering insurer's or third
15 party administrator's term, the board shall invite all
16 insurers, including the administering insurer or third
17 party administrator, to submit bids to serve for the
18 succeeding three-year administration period.
19 Selection of the succeeding administering insurer or
20 third party administrator must be made not later than
21 the sixth calendar month preceding the month in which
22 the administering insurer's or third party
23 administrator's term expires.

24 Revised Law

25 Sec. 1506.204. ADMINISTRATOR'S FUNCTIONS. (a) A pool
26 administrator shall perform the functions relating to the pool that
27 are assigned to the administrator.

28 (b) The assigned functions may include:

29 (1) performing eligibility and administrative claims
30 payment functions for the pool;

31 (2) establishing a billing procedure for collection of
32 premiums from individuals covered by the pool;

33 (3) performing functions necessary to ensure timely
34 payment of benefits to individuals covered by the pool, including:

35 (A) providing information relating to the proper
36 manner of submitting a claim for benefits to the pool and
37 distributing claim forms; and

38 (B) evaluating the eligibility of each claim for
39 payment by the pool;

40 (4) submitting regular reports to the board relating
41 to the operation of the pool; and

42 (5) determining after each calendar year the net

1 written and earned premiums, expenses of administration, and paid
2 and incurred losses of the pool for that calendar year and reporting
3 that information to the board and the commissioner.

4 (c) The board shall determine the form, content, and time of
5 submission of the reports required under Subsection (b)(4).

6 (d) The commissioner shall prescribe the forms to be used to
7 report the information under Subsection (b)(5).

8 (e) The board shall determine the times at which a pool
9 administrator is to perform the billing functions for the pool.

10 (V.T.I.C. Art. 3.77, Secs. 7(e), (g), (h).)

11 Source Law

12 (e) The administering insurer or third party
13 administrator shall perform such functions relating to
14 the pool as may be assigned to it, including:

15 (1) perform eligibility and
16 administrative claims payment functions for the pool;

17 (2) establish a billing procedure for
18 collection of premiums from persons insured by the
19 pool;

20 (3) perform functions necessary to assure
21 timely payment of benefits to persons covered under
22 the pool, including:

23 (A) providing information relating
24 to the proper manner of submitting a claim for benefits
25 to the pool and distributing claim forms; and

26 (B) evaluating the eligibility of
27 each claim for payment by the pool;

28 (4) submit regular reports to the board
29 relating to the operation of the pool; and

30 (5) determine after the close of each
31 calendar year the net written and earned premiums,
32 expense of administration, and paid and incurred
33 losses of the pool for that calendar year and report
34 this information to the board and the commissioner on
35 forms prescribed by the commissioner.

36 (g) The board shall determine the form and
37 content of the report required by Subsection (e)(4) of
38 this section and the time at which reports must be
39 made.

40 (h) The board shall determine the times at which
41 billing for the pool will be done by the administering
42 insurer or third party administrator.

43 Revised Law

44 Sec. 1506.205. PAYMENTS TO ADMINISTRATOR. (a) The pool
45 shall pay a pool administrator for the administrator's expenses
46 incurred in performing duties and functions as provided by the plan
47 of operation.

48 (b) Except as provided by Subsection (c), the total amount

1 of administrative costs and fees paid in a calendar year to all pool
2 administrators may not exceed 12.5 percent of the gross premium
3 receipts of the pool for the calendar year.

4 (c) The commissioner may approve payment of a higher amount,
5 not to exceed 15 percent of the gross premium receipts of the pool
6 for the calendar year, if the commissioner determines that the
7 higher amount is necessary to pay the administrative costs and fees
8 of the pool. (V.T.I.C. Art. 3.77, Sec. 7(f).)

9 Source Law

10 (f) The pool shall pay an administering insurer
11 or third party administrator for its expenses incurred
12 in performing its duties and functions as provided by
13 the plan of operation. Except as otherwise provided by
14 this subsection, the total amount of administrative
15 costs and fees paid in a calendar year to all
16 administering insurers or a third party administrator
17 may not exceed 12.5 percent of the gross premium
18 receipts of the pool for the calendar year. The
19 commissioner may approve payment of a higher amount,
20 not to exceed 15 percent of the gross premium receipts
21 of the pool for the calendar year, if the commissioner
22 determines that the higher amount is necessary to pay
23 the administrative costs and fees of the pool.

24 [Sections 1506.206-1506.250 reserved for expansion]

25 SUBCHAPTER F. ASSESSMENTS FOR OPERATION OF POOL

26 Revised Law

27 Sec. 1506.251. INTERIM ASSESSMENTS. (a) The board may
28 assess health benefit plan issuers, including making advance
29 interim assessments, as reasonable and necessary for the pool's
30 organizational and interim operating expenses.

31 (b) The board shall credit an interim assessment as an
32 offset against any regular assessment that is due after the end of
33 the fiscal year. (V.T.I.C. Art. 3.77, Sec. 13(a).)

34 Source Law

35 Sec. 13. (a) The board may assess insurers and
36 make advance interim assessments as reasonable and
37 necessary for the plan's organizational and interim
38 operating expenses. Any interim assessment shall be
39 credited as offsets against any regular assessments
40 due following the close of the fiscal year.

41 Revised Law

42 Sec. 1506.252. DETERMINATION OF NET LOSS. (a) After the
43 end of each fiscal year, the board shall determine for the preceding

1 calendar year any net loss of the pool, including administrative
2 expenses and incurred losses, and report the net loss to the
3 commissioner.

4 (b) In determining the net loss, the board shall take into
5 account investment income and other appropriate gains and losses.
6 (V.T.I.C. Art. 3.77, Sec. 13(c) (part).)

7 Source Law

8 (c) After the end of each fiscal year, the board
9 shall determine and report to the commissioner the net
10 loss, if any, of the pool for the previous calendar
11 year, including administrative expenses and incurred
12 losses for the year, taking into account investment
13 income and other appropriate gains and losses. . . .

14 Revised Law

15 Sec. 1506.253. ASSESSMENTS TO COVER NET LOSSES. (a) The
16 board shall recover any net loss of the pool by assessing each
17 health benefit plan issuer an amount determined annually by the
18 board based on information in annual statements and other reports
19 required by and filed with the board.

20 (b) The amount of a health benefit plan issuer's assessment
21 is computed by multiplying the total amount required to be assessed
22 against all health benefit plan issuers by a number computed by
23 dividing:

24 (1) the gross premiums collected by the issuer for
25 health benefit plans in this state during the preceding calendar
26 year; by

27 (2) the gross premiums collected by all issuers for
28 health benefit plans in this state during the preceding calendar
29 year.

30 (c) For purposes of Subsection (b), gross health benefit
31 plan premiums do not include Medicare supplement benefit plan
32 premiums subject to Chapter 1652 or small employer health benefit
33 plan premiums subject to Subchapters A-H, Chapter 1501. (V.T.I.C.
34 Art. 3.77, Secs. 13(c) (part), (d) (part).)

35 Source Law

36 (c) . . . Any net loss for the year shall be
37 recouped by assessments on insurers. Each insurer's

1 assessment shall be determined annually by the board
2 based on annual statements and other reports required
3 by the board and filed with the board.

4 (d) The assessment imposed against each insurer
5 shall be in an amount that is equal to the ratio of the
6 gross premiums collected by the insurer for health
7 insurance in this state during the preceding calendar
8 year, except for Medicare supplement premiums subject
9 to Article 3.74 and small group health insurance
10 premiums subject to Articles 26.01 through 26.76, to
11 the gross premiums collected by all insurers for
12 health insurance, except for Medicare supplement
13 premiums subject to Article 3.74 and small group
14 health insurance premiums subject to Articles 26.01
15 through 26.76, in this state during the preceding
16 calendar year. . . .

17 Revisor's Note

18 Section 13(d), V.T.I.C. Article 3.77, refers to
19 "small group health insurance premiums subject to
20 Articles 26.01 through 26.76." V.T.I.C. Chapter 26
21 refers to "small employer health benefit plans" rather
22 than "small group health insurance," and the revised
23 law is drafted accordingly.

24 Revised Law

25 Sec. 1506.254. ASSESSMENT DUE DATE; INTEREST. (a) An
26 assessment is due on the date specified by the board that is not
27 earlier than the 30th day after the date written notice of the
28 assessment is transmitted to the health benefit plan issuer.

29 (b) Interest accrues on the unpaid amount of an assessment
30 at a rate equal to the prime lending rate, as published in the most
31 recent issue of the Wall Street Journal and determined as of the
32 date the assessment becomes delinquent, plus three percent.

33 (V.T.I.C. Art. 3.77, Sec. 13(d) (part).)

34 Source Law

35 (d) . . . An assessment is due on a date
36 specified by the board that may not be earlier than the
37 30th day after the date on which prior written notice
38 of the assessment due is transmitted to the insurer.
39 Interest accrues on the unpaid amount at a rate equal
40 to the prime lending rate, as stated in the most recent
41 issue of the Wall Street Journal, plus three percent,
42 determined as of the date such assessment is
43 delinquent.

44 Revised Law

45 Sec. 1506.255. ABATEMENT OR DEFERMENT OF ASSESSMENT. (a) A
46 health benefit plan issuer may petition the commissioner for an

1 abatement or deferment of all or part of an assessment imposed by
2 the board. The commissioner may abate or defer all or part of the
3 assessment if the commissioner determines that payment of the
4 assessment would endanger the ability of the health benefit plan
5 issuer to fulfill its contractual obligations.

6 (b) If all or part of an assessment against a health benefit
7 plan issuer is abated or deferred, the amount of the abatement or
8 deferment shall be assessed against the other health benefit plan
9 issuers in a manner consistent with the method for computing
10 assessments under this subchapter.

11 (c) A health benefit plan issuer receiving an abatement or
12 deferment under this section remains liable to the pool for the
13 deficiency. (V.T.I.C. Art. 3.77, Sec. 13(e).)

14 Source Law

15 (e) An insurer may petition the commissioner for
16 an abatement or deferment of all or part of an
17 assessment imposed by the board. The commissioner may
18 abate or defer all or part of the assessment if the
19 commissioner determines that payment of the assessment
20 would endanger the ability of the insurer to fulfill
21 its contractual obligations. If all or part of an
22 assessment against an insurer is abated or deferred,
23 the amount by which the assessment is abated or
24 deferred shall be assessed against the other insurers
25 in a manner consistent with the basis for computing
26 assessments under this section. An insurer receiving
27 an abatement or deferment under this subsection
28 remains liable to the pool for the deficiency.

29 Revised Law

30 Sec. 1506.256. USE OF EXCESS FROM ASSESSMENTS. (a) In
31 this section, "future losses" includes reserves for claims incurred
32 but not reported.

33 (b) If the total amount of the assessments exceeds the
34 pool's actual losses and administrative expenses, the board shall
35 deposit the excess in an interest-bearing account and shall use
36 money in that account to offset future losses or to reduce future
37 assessments. (V.T.I.C. Art. 3.77, Sec. 13(b).)

38 Source Law

39 (b) If assessments exceed the pool's actual
40 losses and administrative expenses, the excess shall
41 be held in an interest-bearing account and used by the
42 board to offset future losses or to reduce future

1 assessments. As used in this section, future losses
2 includes reserves for incurred but not reported
3 claims.

4 Revised Law

5 Sec. 1506.257. COLLECTION OF ASSESSMENTS. The pool may
6 recover or collect assessments made under this subchapter.
7 (V.T.I.C. Art. 3.77, Sec. 6(b) (part).)

8 Source Law

9 (b) As part of its authority, the pool may:

10 . . .
11 (11) recover or collect assessments
12 imposed under Section 13 of this article;
13 . . .

14 Revised Law

15 Sec. 1506.258. PROCEDURES, CRITERIA, AND FORMS. The
16 commissioner by rule shall provide the procedures, criteria, and
17 forms necessary to implement, collect, and deposit assessments
18 under this subchapter. (V.T.I.C. Art. 3.77, Sec. 8 (part).)

19 Source Law

20 Sec. 8. . . . The commissioner by rule shall
21 provide the procedures, criteria, and forms necessary
22 to implement, collect, and deposit assessments made
23 and collected under Section 13.

24 [Chapters 1507-1550 reserved for expansion]

25 SUBTITLE I. SPECIALIZED COVERAGES

26 CHAPTER 1651. LONG-TERM CARE BENEFIT PLANS

27 SUBCHAPTER A. GENERAL PROVISIONS

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34 [Sections 1651.007-1651.050 reserved for expansion]

35 SUBCHAPTER B. BENEFIT PLAN STANDARDS

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1 Sec. 1651.055. RATE STABILIZATION 1359

2 CHAPTER 1651. LONG-TERM CARE BENEFIT PLANS

3 SUBCHAPTER A. GENERAL PROVISIONS

4 Revised Law

5 Sec. 1651.001. APPLICABILITY OF CHAPTER. (a)

6 Notwithstanding Section 101.053(b)(5) and subject to Subsection
7 (b), this chapter applies only to:

8 (1) an individual long-term care benefit plan that is
9 delivered or issued for delivery in this state;

10 (2) a group long-term care benefit plan that is:

11 (A) delivered or issued for delivery in this
12 state; and

13 (B) issued to an eligible group as described by
14 Subchapter B, Chapter 1251;

15 (3) a certificate issued under a group long-term care
16 benefit plan issued to an eligible group as described by Subchapter
17 B, Chapter 1251, if the certificate is delivered or issued for
18 delivery in this state, regardless of the place where the plan is
19 delivered or issued for delivery; and

20 (4) an evidence of coverage delivered or issued for
21 delivery in this state for long-term care.

22 (b) This chapter applies only to a policy, certificate, or
23 evidence of coverage that is issued by:

24 (1) a capital stock insurance company, including a
25 life, health and accident, or general casualty insurance company;

26 (2) a mutual life insurance company;

27 (3) a mutual assessment life insurance company,
28 including a statewide mutual assessment corporation, local mutual
29 aid association, and burial association;

30 (4) a mutual or mutual assessment association,
31 including an association subject to Section 887.101;

32 (5) a mutual insurance company other than a life
33 insurance company;

34 (6) a mutual or natural premium life or casualty

- 1 insurance company;
- 2 (7) a fraternal benefit society;
- 3 (8) a Lloyd's plan insurer;
- 4 (9) a reciprocal or interinsurance exchange;
- 5 (10) a nonprofit medical, hospital, or dental service
- 6 corporation, including a company subject to Chapter 842;
- 7 (11) a stipulated premium company;
- 8 (12) a health maintenance organization under Chapter
- 9 843; or
- 10 (13) another insurer required to be licensed by the
- 11 department. (V.T.I.C. Art. 3.70-12, Secs. 1(a), (b), 2(2), (3).)

12 Source Law

13 Art. 3.70-12

14 Sec. 1. (a) Notwithstanding Section 2(b)(5) of

15 Article 1.14-1 of this code, this article applies to

16 and governs individual and group long-term care

17 insurance policies delivered or issued for delivery in

18 this state and certificates issued under group

19 long-term care insurance policies that have been

20 delivered or issued for delivery in this state, if

21 those policies or certificates are issued by:

22 (1) capital stock companies, including but

23 not limited to life, health and accident, and general

24 casualty companies;

25 (2) mutual life insurance companies;

26 (3) mutual assessment life insurance

27 companies, including statewide mutual assessment

28 corporations, local mutual aids, and burial

29 associations;

30 (4) mutual and mutual assessment

31 associations of all kinds and types, including

32 associations subject to Article 14.17 of this code;

33 (5) mutual insurance companies other than

34 life companies;

35 (6) mutual or natural premium life or

36 casualty insurance companies;

37 (7) fraternal benefit societies;

38 (8) Lloyd's plan insurers;

39 (9) reciprocal or inter-insurance

40 exchanges;

41 (10) nonprofit hospital, medical or dental

42 service corporations, including companies subject to

43 Chapter 20 of this code;

44 (11) stipulated premium insurance

45 companies; or

46 (12) any other insurer which by law is

47 required to be licensed by the Texas Department of

48 Insurance.

49 (b) This article shall apply to evidences of

50 coverage delivered or issued for delivery for

51 long-term care in this state by health maintenance

52 organizations under the Texas Health Maintenance

53 Organization Act (Chapter 20A, Vernon's Texas

54 Insurance Code).

1 Sec. 2. In this article:

2 (2) "Certificate" means any certificate
3 issued under a group long-term insurance policy, which
4 certificate has been delivered or issued for delivery
5 in this state, regardless of the place where the policy
6 was delivered or issued for delivery.

7 (3) "Group long-term care insurance" means
8 any long-term care insurance policy or certificate of
9 group long-term care insurance which is delivered or
10 issued for delivery in this state and issued to an
11 eligible group as defined by Section 1(a), Article
12 3.51-6 of this code.

13 Revisor's Note

14 (1) Section 1(a), V.T.I.C. Article 3.70-12,
15 states that this article "applies to and governs"
16 certain long-term care insurance policies. The
17 revised law omits "governs" because, in context,
18 "governs" is included in the meaning of "applies to."

19 (2) Sections 1(a) and 2(2), V.T.I.C. Article
20 3.70-12, refer to long-term care "insurance policies,"
21 and Section 2(3), V.T.I.C. Article 3.70-12, defines
22 group long-term care "insurance." The revised law
23 substitutes "benefit plan" for the references to
24 insurance policies and insurance because V.T.I.C.
25 Article 3.70-12, revised as this chapter, applies to
26 evidences of coverage for long-term care issued by
27 health maintenance organizations. Health maintenance
28 organizations provide health benefit coverage, but the
29 organizations are not insurers. Consequently,
30 "benefit plan" is a more accurate term than "insurance
31 policy" or "insurance." The substitution of "benefit
32 plan," as well as any comparable change necessary to
33 ensure consistent terminology, is made throughout this
34 chapter.

35 (3) Section 1(a)(1), V.T.I.C. Article 3.70-12,
36 refers to "including but not limited to." "But not
37 limited to" is omitted as unnecessary because Section
38 311.005(13), Government Code (Code Construction Act),
39 and Section 312.011(19), Government Code, provide that

1 "includes" and "including" are terms of enlargement
2 and not of limitation and do not create a presumption
3 that components not expressed are excluded.

4 Revised Law

5 Sec. 1651.002. EXEMPTIONS. This chapter does not apply to:

6 (1) a certificate that is delivered or issued for
7 delivery in this state under a single employer or labor union group
8 policy that is delivered or issued for delivery outside this state;
9 or

10 (2) a benefit plan that is not advertised, marketed,
11 or offered as a long-term care benefit plan or nursing home benefit
12 plan. (V.T.I.C. Art. 3.70-12, Secs. 1(d), (e).)

13 Source Law

14 (d) This article does not apply to certificates
15 that are delivered or issued for delivery in this state
16 under a single employer or labor union group policy
17 that is delivered or issued for delivery outside this
18 state.

19 (e) This article does not apply to a policy that
20 is not advertised, marketed, or offered as long-term
21 care insurance or nursing home insurance.

22 Revised Law

23 Sec. 1651.003. LONG-TERM CARE BENEFIT PLAN DEFINED. (a) In
24 this chapter, "long-term care benefit plan" means an insurance
25 policy or group certificate, or rider to the policy or certificate,
26 or evidence of coverage issued by a health maintenance organization
27 subject to Chapter 843, that is advertised or marketed as
28 providing, or offered or designed to provide, coverage for not less
29 than 12 consecutive months for each covered individual on an
30 expense-incurred, indemnity, prepaid, or other basis for one or
31 more necessary or medically necessary diagnostic, preventive,
32 therapeutic, rehabilitative, maintenance, or personal care
33 services provided in a setting other than an acute care unit of a
34 hospital.

35 (b) The term includes a plan or rider, other than a group or
36 individual annuity or life insurance policy, that provides for
37 payment of benefits based on cognitive impairment or the loss of

1 functional capacity.

2 (c) The term does not include an insurance policy, group
3 certificate, or evidence of coverage that is offered primarily to
4 provide:

5 (1) basic Medicare supplement coverage, basic
6 hospital expense coverage, basic medical-surgical expense
7 coverage, hospital confinement indemnity coverage, major medical
8 expense coverage, disability income protection coverage,
9 accident-only coverage, specified disease or specified accident
10 coverage, or limited benefit health coverage; or

11 (2) basic or single health care services. (V.T.I.C.
12 Art. 3.70-12, Sec. 2(4).)

13 Source Law

14 Sec. 2. In this article:

15 (4) "Long-term care insurance policy"
16 means any insurance policy, group certificate, or
17 rider to such policy or certificate, or evidence of
18 coverage issued by a health maintenance organization
19 subject to the Texas Health Maintenance Organization
20 Act (Chapter 20A, Vernon's Texas Insurance Code),
21 which policy, certificate, rider or evidence of
22 coverage is advertised, marketed, offered, or designed
23 to provide coverage for not less than 12 consecutive
24 months for each covered person on an expense-incurred,
25 indemnity, prepaid, or other basis for one or more
26 necessary or medically necessary diagnostic,
27 preventive, therapeutic, rehabilitative, maintenance,
28 or personal care services, provided in a setting other
29 than an acute care unit of a hospital. The term also
30 includes a policy or rider, other than a group or
31 individual annuity or life insurance policy, that
32 provides for payment of benefits based on cognitive
33 impairment or the loss of functional capacity. The
34 term "long-term care insurance" shall not include any
35 insurance policy or group certificate which is offered
36 primarily to provide basic Medicare supplement
37 coverage, basic hospital expense coverage, basic
38 medical-surgical expense coverage, hospital
39 confinement indemnity coverage, major medical expense
40 coverage, disability income protection coverage,
41 accident only coverage, specified disease or specified
42 accident coverage, limited benefit health coverage, or
43 basic or single health care services.

44 Revisor's Note

45 Section 2(4), V.T.I.C. Article 3.70-12, in the
46 third sentence, excludes "any insurance policy or
47 group certificate" from the scope of the defined term
48 if the policy or certificate provides certain

1 specified coverage. The revised law adds a reference
2 to "evidence of coverage" to the exclusionary language
3 for clarity and consistency with the remainder of
4 Section 2(4). The first sentence of Section 2(4)
5 provides that "evidence of coverage" is included in
6 the scope of the defined term in some instances.
7 Consequently, in context, it is clear that "evidence
8 of coverage" should be excluded in the instances
9 described in the third sentence of Section 2(4).

10 Revised Law

11 Sec. 1651.004. RULES. (a) In addition to other rules
12 required or authorized by this chapter, the department may adopt
13 reasonable rules that are necessary and proper to carry out this
14 chapter.

15 (b) Rules adopted under this section must include
16 requirements no less favorable than the minimum standards for
17 long-term care benefit plans adopted in any model laws or
18 regulations relating to minimum standards for benefits for
19 long-term care benefit plans and in accordance with all applicable
20 federal law. (V.T.I.C. Art. 3.70-12, Sec. 7.)

21 Source Law

22 Sec. 7. In addition to other rules required or
23 authorized by this article, the State Board of
24 Insurance may adopt reasonable rules that are
25 necessary and proper to carry out this article. Any
26 rules so adopted shall include requirements no less
27 favorable than minimum standards for long-term care
28 insurance adopted in any model laws or regulations
29 relating to minimum standards for benefits for
30 long-term care insurance and in accordance with all
31 applicable federal law.

32 Revisor's Note

33 Section 7, V.T.I.C. Article 3.70-12, refers to
34 "the State Board of Insurance." Chapter 685, Acts of
35 the 73rd Legislature, Regular Session, 1993, abolished
36 the board and transferred its functions to the
37 commissioner of insurance and the Texas Department of
38 Insurance. Throughout this chapter, references to the

1 board have been changed appropriately.

2 Revised Law

3 Sec. 1651.005. CONSTRUCTION OF CHAPTER. This chapter may
4 not be construed to enlarge the powers of an entity listed in
5 Section 1651.001. (V.T.I.C. Art. 3.70-12, Sec. 1(c).)

6 Source Law

7 (c) This article may not be construed to enlarge
8 the powers of any of the enumerated companies.

9 Revised Law

10 Sec. 1651.006. CONFLICTS WITH OTHER PROVISIONS. This
11 chapter prevails to the extent of any conflict with another
12 provision of this code. (V.T.I.C. Art. 3.70-12, Sec. 6 (part).)

13 Source Law

14 Sec. 6. . . . in the event of any conflict
15 between a provision of this article and any other
16 provisions of this code, the provision of this article
17 controls to the extent of the conflict. . . .

18 Revisor's Note

19 (1) Section 6, V.T.I.C. Article 3.70-12, refers
20 to the cumulative effect of that article. An accepted
21 general principle of statutory construction requires a
22 statute to be given cumulative effect with other
23 statutes unless it provides otherwise or unless the
24 statutes are in conflict. The general principle
25 applies to this revision. The omitted law reads:

26 Sec. 6. This article is cumulative of
27 all other law, but

28 (2) The portion of Section 6, V.T.I.C. Article
29 3.70-12, that provides that the article is severable
30 is omitted because that provision duplicates Section
31 311.032, Government Code (Code Construction Act),
32 applicable to the revised law, and Section 312.013,
33 Government Code. These provisions state that a
34 provision of a statute is severable from each other
35 provision of the statute that can be given effect. The
36 omitted law reads:

1 Sec. 6. . . . If any provision of
2 this article or the application of any
3 provision of this article to any person or
4 circumstance is for any reason held to be
5 invalid, the remainder of this article and
6 the application of that provision to other
7 persons or circumstances shall not be
8 affected by the invalidity.

9 [Sections 1651.007-1651.050 reserved for expansion]

10 SUBCHAPTER B. BENEFIT PLAN STANDARDS

11 Revised Law

12 Sec. 1651.051. MINIMUM STANDARDS. (a) The commissioner by
13 rule shall establish:

14 (1) specific standards for provisions of long-term
15 care benefit plans; and

16 (2) standards for full and fair disclosure setting
17 forth the manner, content, and required disclosures for the
18 marketing and sale of those benefit plans.

19 (b) The standards are in addition to and must be in
20 accordance with:

21 (1) applicable laws of this state, including Chapter
22 1201;

23 (2) applicable federal law; and

24 (3) any rules, regulations, and standards required by
25 federal law.

26 (c) The standards must address:

27 (1) terms of renewability;

28 (2) initial and subsequent conditions of eligibility;

29 (3) nonduplication of coverage;

30 (4) coverage of dependents;

31 (5) coverage of parents of the insured or enrollee and
32 parents of the spouse of the insured or enrollee;

33 (6) preexisting conditions;

34 (7) termination of insurance;

35 (8) continuation or conversion;

36 (9) probationary periods;

37 (10) benefit limitations, exceptions, and reductions;

38 (11) elimination periods;

- 1 (12) requirements for replacement;
- 2 (13) recurrent conditions;
- 3 (14) definitions of terms; and
- 4 (15) inflation protection.
- 5 (d) The standards may:
- 6 (1) establish standard claim forms;
- 7 (2) establish standard benefits for:
- 8 (A) skilled nursing care;
- 9 (B) intermediate nursing care;
- 10 (C) custodial care; and
- 11 (D) home health care;
- 12 (3) require coverage for skilled nursing care,
- 13 intermediate nursing care, and custodial care to facilitate
- 14 comparison among long-term care products;
- 15 (4) require long-term care benefit plan issuers to
- 16 offer coverage for home health care benefits;
- 17 (5) require that rates may not be increased for a
- 18 covered individual unless:
- 19 (A) the covered individual requests and receives
- 20 a change of benefits; or
- 21 (B) the increase applies to all members of the
- 22 class to which the individual has been assigned by the benefit plan
- 23 issuer; or
- 24 (6) require a benefit plan issuer to pay for a service
- 25 covered by the benefit plan that is provided by an institution
- 26 licensed to provide that service under Chapter 242, Health and
- 27 Safety Code.
- 28 (e) Rules adopted under this section must include
- 29 requirements no less favorable than the minimum standards of
- 30 benefits for long-term care benefit plans adopted in any model laws
- 31 or regulations relating to minimum standards for benefits for
- 32 long-term care benefit plans and required by federal law.
- 33 (V.T.I.C. Art. 3.70-12, Secs. 3(a), (b), (c), (d).)

1 Source Law

2 Sec. 3. (a) The State Board of Insurance by
3 rule shall establish specific standards for provisions
4 of long-term care insurance policies and standards for
5 full and fair disclosure setting forth the manner,
6 content, and required disclosures for the marketing
7 and sale of long-term care insurance policies. Those
8 standards are in addition to and in accordance with
9 applicable laws of this state, including Subchapter G
10 of Chapter 3 of this code, applicable federal law, and
11 any rules, regulations, and standards required by
12 federal law.

13 (b) The standards established under Subsection
14 (a) of this section shall cover the following:

- 15 (1) terms of renewability;
- 16 (2) initial and subsequent conditions of
17 eligibility;
- 18 (3) nonduplication of coverage;
- 19 (4) coverage of dependents;
- 20 (5) coverage of parents of the insured and
21 parents of the spouse of the insured;
- 22 (6) preexisting conditions;
- 23 (7) termination of insurance;
- 24 (8) continuation or conversion;
- 25 (9) probationary periods;
- 26 (10) benefit limitations, exceptions, and
27 reductions;
- 28 (11) elimination periods;
- 29 (12) requirements for replacement;
- 30 (13) recurrent conditions;
- 31 (14) definitions of terms; and
- 32 (15) inflation protection.

33 (c) The standards established under Subsection
34 (a) of this section may:

- 35 (1) establish standard claim forms;
- 36 (2) establish standard benefits for:
 - 37 (A) skilled nursing care;
 - 38 (B) intermediate nursing care;
 - 39 (C) custodial care; and
 - 40 (D) home health care;
- 41 (3) require coverage for skilled nursing
42 care, intermediate nursing care, and custodial care to
43 facilitate comparison among long-term care insurance
44 products;
- 45 (4) require insurers to offer coverage for
46 home health care benefits;
- 47 (5) require that premium rates may not be
48 raised for a covered individual unless either the
49 covered individual requests and receives a change of
50 benefits or the increase is made for all members of the
51 class to which the individual has been assigned by the
52 insurer; or
- 53 (6) require an insurer to pay for services
54 covered by the policy that are rendered by any
55 institution licensed to provide those services under
56 Chapter 242, Health and Safety Code.

57 (d) Any rules issued by the State Board of
58 Insurance under this section shall include
59 requirements no less favorable than the minimum
60 standards of benefits for long-term care insurance
61 adopted in any model laws or regulations relating to
62 minimum standards for benefits for long-term care
63 insurance and mandated by federal law.

64 Revisor's Note

- 65 (1) Section 3(a), V.T.I.C. Article 3.70-12,

1 refers to the "applicable laws of this state,
2 including Subchapter G of Chapter 3" of the Insurance
3 Code. The majority of Subchapter G, Chapter 3,
4 Insurance Code, and the provisions primarily
5 applicable to long-term care benefit plans, are
6 revised as Chapter 1201 of this code. The revised law
7 is drafted accordingly.

8 (2) Section 3(b)(5), V.T.I.C. Article 3.70-12,
9 refers to "the insured." The revised law adds a
10 reference to an "enrollee" because this chapter
11 applies to a health maintenance organization that
12 provides long-term care coverage. "Enrollee" is the
13 proper term to refer to a person covered under a
14 benefit plan provided by a health maintenance
15 organization.

16 Revised Law

17 Sec. 1651.052. PREEXISTING CONDITIONS. (a) A long-term
18 care benefit plan may not contain a provision that denies coverage
19 for a claim for losses incurred more than six months after the
20 effective date of coverage for a preexisting condition.

21 (b) A long-term care benefit plan may not define a
22 preexisting condition more restrictively than as a condition for
23 which medical advice was given or treatment was recommended by or
24 received from a physician within six months before the effective
25 date of coverage.

26 (c) The commissioner by rule may:

27 (1) establish additional reasonable regulation of
28 preexisting conditions consistent with this section and Section
29 1651.051; and

30 (2) extend a limitation period specified in this
31 section as to a specific age group category in a specific benefit
32 plan form if the commissioner finds that the extension is in the
33 best interest of the public.

34 (d) Rules adopted under this section must comply with

1 Section 1651.051(e). (V.T.I.C. Art. 3.70-12, Secs. 3(d), (e).)

2 Source Law

3 (d) Any rules issued by the State Board of
4 Insurance under this section shall include
5 requirements no less favorable than the minimum
6 standards of benefits for long-term care insurance
7 adopted in any model laws or regulations relating to
8 minimum standards for benefits for long-term care
9 insurance and mandated by federal law.

10 (e) In addition to other provisions of this
11 section, a long-term care insurance policy or
12 certificate subject to this article may not contain a
13 provision which denies a claim for losses incurred
14 more than six months from the effective date of
15 coverage for a preexisting condition. A policy may not
16 define a preexisting condition more restrictively than
17 a condition for which medical advice was given or
18 treatment was recommended by or received from a
19 physician within six months before the effective date
20 of coverage. The State Board of Insurance by rule may
21 provide for additional reasonable regulation of
22 preexisting conditions consistent with this section.
23 That authority includes the authority to extend the
24 limitations periods set forth in this section as to
25 specific age group categories in specific policy
26 forms, based on the board's first finding that such an
27 extension is in the best interest of the public.

28 Revisor's Note

29 Section 3(e), V.T.I.C. Article 3.70-12, refers to
30 a long-term care "certificate." Throughout this
31 chapter, the revised law omits "certificate" as
32 unnecessary in this context because the term is
33 included in the meaning of "long-term care benefit
34 plan" as defined in Section 1651.003.

35 Revised Law

36 Sec. 1651.053. LOSS RATIO STANDARDS. (a) A long-term
37 care benefit plan must provide a benefit plan holder with benefits
38 that are reasonable in relation to the rates charged.

39 (b) The commissioner shall adopt reasonable rules to
40 establish minimum standards for loss ratios of long-term care
41 benefit plans on the basis of:

- 42 (1) incurred claims experience;
- 43 (2) earned premiums;
- 44 (3) the period for which rates are computed to provide
45 coverage;
- 46 (4) experienced and projected trends;

1 (5) concentration of experience within early benefit
2 plan duration;
3 (6) expected claim fluctuations;
4 (7) experience refunds;
5 (8) adjustments;
6 (9) dividends;
7 (10) renewability features;
8 (11) all relevant expense factors;
9 (12) interest;
10 (13) reserves;
11 (14) mix of business by risk classification; and
12 (15) product features otherwise affecting claims
13 experience.

14 (c) Annually, each entity providing a long-term care
15 benefit plan in this state shall:

16 (1) file its rates, rating schedule, and supporting
17 documentation to demonstrate compliance with the applicable loss
18 ratio standards of this state; and

19 (2) comply with any other filing requirement adopted
20 by the commissioner relating to loss ratios.

21 (d) Rules adopted under this section shall be no less
22 favorable to the holders of long-term care benefit plans than any
23 model laws, rules, and regulations adopted in connection with
24 minimum standards for benefits for long-term care benefit plans.

25 (V.T.I.C. Art. 3.70-12, Sec. 4.)

26 Source Law

27 Sec. 4. (a) Long-term care insurance policies
28 shall return to holders of the policies benefits that
29 are reasonable in relation to the premium charged. The
30 State Board of Insurance shall adopt reasonable rules
31 to establish minimum standards for loss ratios of
32 long-term care insurance policies on the basis of
33 incurred claims experience, earned premiums, the
34 period for which rates are computed to provide
35 coverage, experienced and projected trends,
36 concentration of experience within early policy
37 duration, expected claim fluctuation, experience
38 refunds, adjustments, dividends, renewability
39 features, all relevant expense factors, interest,
40 policy reserves, mix of business by risk
41 classification, and product features otherwise

1 affecting claims experience.

2 (b) Each entity providing long-term care
3 insurance in this state annually shall file its rates,
4 rating schedule, and supporting documentation
5 demonstrating that it is in compliance with the
6 applicable loss ratio standards of this state, as well
7 as any other filing requirements relating to loss
8 ratios promulgated under rules adopted by the State
9 Board of Insurance.

10 (c) The State Board of Insurance shall adopt
11 reasonable rules providing loss ratio standards
12 applicable to rates charged for long-term care
13 insurance policies. The rules adopted shall be no less
14 favorable to the holders of those policies than any
15 model laws, rules, and regulations adopted in
16 connection with minimum standards for benefits for
17 long-term care insurance.

18 Revised Law

19 Sec. 1651.054. NOTICE OF RIGHT TO REFUND. (a) In this
20 section, "applicant" means:

21 (1) in the case of an individual long-term care
22 benefit plan, the individual who seeks to contract for insurance or
23 other health benefits; and

24 (2) in the case of a group long-term care benefit plan,
25 the proposed certificate holder.

26 (b) A long-term care benefit plan must have a notice
27 prominently printed on the first page of or attached to the benefit
28 plan document.

29 (c) The notice must state in substance that, if the
30 applicant is not satisfied for any reason after examining the
31 benefit plan document, the applicant is entitled to:

32 (1) return the document not later than the 30th day
33 after the date of its delivery; and

34 (2) have any premium refunded.

35 (d) The long-term care benefit plan issuer shall pay in a
36 timely manner the refund directly to the individual or entity that
37 paid the premium. (V.T.I.C. Art. 3.70-12, Secs. 2(1), 5.)

38 Source Law

39 Sec. 2. In this article:

40 (1) "Applicant" means:

41 (A) in the case of an individual
42 long-term care insurance policy, the person who seeks
43 to contract for insurance or other health benefits;
44 and

45 (B) in the case of a group long-term
46 care insurance policy, the proposed certificate

1 holder.

2 Sec. 5. Each long-term care insurance policy or
3 certificate must have a notice prominently printed on
4 the first page of or attached to the policy or
5 certificate stating in substance that the applicant
6 has the right to return the policy or certificate
7 within 30 days of the date of its delivery and to have
8 the premium refunded if, after examination of the
9 policy or certificate, the applicant is not satisfied
10 for any reason. The entity issuing the policy or
11 certificate shall pay in a timely manner a refund made
12 under this section directly to the person or entity
13 that remitted the premium.

14 Revised Law

15 Sec. 1651.055. RATE STABILIZATION. (a) The commissioner
16 shall adopt rules to stabilize long-term care premium rates by:

17 (1) ensuring that:

18 (A) initial rates for long-term care benefit plan
19 forms are adequate; and

20 (B) any rate schedule increases for long-term
21 care benefit plans made after issuance of the plans are justified,
22 adequate, and reasonable in relation to benefits provided to plan
23 holders;

24 (2) requiring any appropriate plan terms;

25 (3) imposing penalties on insurers or other entities
26 subject to this chapter that violate a rule adopted under this
27 section; and

28 (4) protecting plan holders affected by a rate
29 schedule increase.

30 (b) Except as provided by this subsection, the commissioner
31 shall adopt rules under this section that are consistent with
32 nationally recognized models relating to the stabilization of
33 long-term care premium rates that existed on January 1, 2001. The
34 commissioner may adopt rules consistent with any of those models as
35 they are amended after January 1, 2001. The commissioner shall
36 adopt rules under this subsection that:

37 (1) to the extent possible, contribute to the
38 uniformity of state laws; and

39 (2) protect consumers.

40 (c) In adopting rules under this section, the commissioner

1 may exempt long-term care benefit plans from the requirements of
2 Sections 1651.053(a), (b), and (d). (V.T.I.C. Art. 3.70-12, Sec.
3 5A.)

4 Source Law

5 Sec. 5A. (a) The commissioner shall adopt rules
6 to stabilize long-term care insurance premium rates
7 by:

8 (1) ensuring that:

9 (A) initial rates for long-term care
10 insurance policy forms are adequate; and

11 (B) any rate schedule increases for
12 long-term care insurance policies made after issuance
13 of the policies are justified, adequate, and
14 reasonable in relation to benefits provided to policy
15 or certificate holders;

16 (2) requiring any appropriate policy
17 terms;

18 (3) imposing penalties on insurers or
19 other entities subject to this article that violate a
20 rule adopted under this section; and

21 (4) protecting policy and certificate
22 holders affected by a rate schedule increase.

23 (b) Except as provided by this subsection, the
24 commissioner shall adopt rules under this section that
25 are consistent with nationally recognized models
26 relating to the stabilization of long-term care
27 insurance premium rates that existed on January 1,
28 2001. The commissioner may adopt rules consistent
29 with any of those models as they are amended after
30 January 1, 2001. The commissioner shall adopt rules
31 under this subsection that:

32 (1) to the extent possible, contribute to
33 the uniformity of state laws; and

34 (2) protect consumers.

35 (c) In adopting rules under this section, the
36 commissioner may exempt long-term care insurance
37 policies from the requirements of Sections 4(a) and
38 (c) of this article.

39 CHAPTER 1652. MEDICARE SUPPLEMENT BENEFIT PLANS

40 SUBCHAPTER A. GENERAL PROVISIONS

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46 [Sections 1652.006-1652.050 reserved for expansion]

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8 [Sections 1652.059-1652.100 reserved for expansion]

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24 [Sections 1652.157-1652.200 reserved for expansion]

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28 CHAPTER 1652. MEDICARE SUPPLEMENT BENEFIT PLANS

29 SUBCHAPTER A. GENERAL PROVISIONS

30 Revised Law

31 Sec. 1652.001. DEFINITIONS. In this chapter:

32 (1) "Applicant" means:

33 (A) an individual who seeks to contract for

34 insurance or other health benefits under an individual Medicare

1 supplement benefit plan; or

2 (B) the proposed certificate holder of a group
3 Medicare supplement benefit plan.

4 (2) "Approved regulatory program" means a state
5 regulatory program that complies with the requirements of Section
6 1882, Social Security Act (42 U.S.C. Section 1395ss).

7 (3) "Medicare" means the Health Insurance for the Aged
8 Act (42 U.S.C. Section 1395 et seq.), as amended. (V.T.I.C. Art.
9 3.74, Secs. 1(b)(1), (4); New.)

10 Source Law

11 (b) Definitions.

12 (1) "Applicant" means:

13 (A) in the case of an individual
14 medicare supplement policy, the person who seeks to
15 contract for insurance or other health benefits, and

16 (B) in the case of a group medicare
17 supplement policy, the proposed certificate holder.

18 (4) "Medicare" means the Health Insurance
19 for the Aged Act, Part 1 of Title I of the Social
20 Security Amendments of 1965, as amended (Public Law
21 89-97).

22 Revisor's Note

23 (1) Section 1(b)(1), V.T.I.C. Article 3.74,
24 refers to a "medicare supplement policy." The revised
25 law substitutes "benefit plan" for "policy" because
26 V.T.I.C. Article 3.74, revised as this chapter,
27 applies to evidences of coverage issued by health
28 maintenance organizations to supplement
29 reimbursements under Medicare. Health maintenance
30 organizations provide health benefit coverage, but the
31 organizations are not insurers, which issue policies.
32 Consequently, "benefit plan" is a more accurate term
33 than "policy." The substitution of "benefit plan" and
34 comparable changes necessary to ensure consistency in
35 terminology are made throughout this chapter.

36 (2) Section 1(b)(4), V.T.I.C. Article 3.74,
37 refers to the "Health Insurance for the Aged Act, Part
38 1 of Title I of the Social Security Amendments of 1965,

1 as amended (Public Law 89-97)." The correct citation
2 for that federal law is 42 U.S.C. Section 1395 et seq.,
3 and the revised law is drafted accordingly.

4 (3) The definition of "approved regulatory
5 program" is added to the revised law for drafting
6 convenience and to eliminate frequent, unnecessary
7 repetition of the substance of the definition.

8 Revised Law

9 Sec. 1652.002. MEDICARE SUPPLEMENT BENEFIT PLAN. (a)
10 "Medicare supplement benefit plan" means a group or individual
11 policy of accident and health insurance, a subscriber contract of a
12 group hospital service corporation operating under Chapter 842, or,
13 to the extent required by federal law, an evidence of coverage
14 issued by a health maintenance organization operating under Chapter
15 843 that is advertised, marketed, or designed primarily as a
16 supplement to reimbursements under Medicare for the hospital,
17 medical, or surgical expenses of an individual eligible for
18 Medicare.

19 (b) A policy, contract, subscriber contract, or evidence of
20 coverage is not considered to be a Medicare supplement benefit plan
21 if it is:

22 (1) a policy, contract, subscriber contract, or
23 evidence of coverage of one or more employers or labor
24 organizations, or of the trustees of a fund established by one or
25 more employers or labor organizations, or a combination, for
26 employees or former employees, or a combination, or for members or
27 former members, or a combination, of the labor organizations;

28 (2) a policy or health care benefit plan, including a
29 policy or contract of group insurance, a group contract of a group
30 hospital service corporation operating under Chapter 842, or a
31 group evidence of coverage issued by a health maintenance
32 organization operating under Chapter 843 that is not marketed or
33 held to be a Medicare supplement benefit plan; or

34 (3) an individual or group evidence of coverage issued

1 in accordance with a contract under Section 1833 or 1876, Social
2 Security Act (42 U.S.C. Section 13951 or 1395mm), by a health
3 maintenance organization operating under Chapter 843.

4 (c) The commissioner by rule may modify the definition of
5 "Medicare supplement benefit plan" provided by Subsection (a) to
6 the extent necessary for this state to qualify as a state with an
7 approved regulatory program. (V.T.I.C. Art. 3.74, Sec. 1(b)(3).)

8 Source Law

9 (3) "Medicare supplement policy" means a
10 group or individual policy of accident and sickness
11 insurance or a subscriber contract of a hospital
12 service corporation subject to Chapter 20 of this code
13 or, to the extent required by federal law, an evidence
14 of coverage issued by a health maintenance
15 organization subject to the Texas Health Maintenance
16 Organization Act, as amended (Chapter 20A, Vernon's
17 Texas Insurance Code), which policy, subscriber
18 contract, or such evidence of coverage is advertised,
19 marketed, or designed primarily as a supplement to
20 reimbursements under medicare for the hospital,
21 medical, or surgical expenses of persons eligible for
22 medicare; provided that the State Board of Insurance
23 may by rule modify the definition of medicare
24 supplement policy to the extent necessary for the
25 State of Texas to qualify as a state with an approved
26 regulatory program under the provisions of Public Law
27 96-265, Section 507(a), 94 Stat. 476 (42 U.S.C.A.
28 Section 1395ss (1980)). Such term does not include:

29 (A) a policy, contract, subscriber
30 contract, or evidence of coverage of one or more
31 employers or labor organizations, or of the trustees
32 of a fund established by one or more employers or labor
33 organizations, or combination thereof, for employees
34 or former employees, or combination thereof, or for
35 members or former members, or combination thereof, of
36 the labor organizations;

37 (B) a policy or health care benefit
38 plan including a policy or contract of group insurance
39 or group contract of a hospital service corporation
40 subject to Chapter 20 of this code or group evidence of
41 coverage issued by a health maintenance organization
42 subject to the Texas Health Maintenance Organization
43 Act (Chapter 20A, Vernon's Texas Insurance Code), when
44 such policy or plan is not marketed or held to be a
45 medicare supplement policy or benefit plan; or

46 (C) an individual or group evidence
47 of coverage issued pursuant to a contract under
48 Section 1876 or Section 1833 of the Federal Social
49 Security Act (42 U.S.C.A. Section 1395, et seq.) by a
50 health maintenance organization subject to the Texas
51 Health Maintenance Organization Act (Chapter 20A,
52 Vernon's Texas Insurance Code).

53 Revisor's Note

54 (1) Section 1(b)(3), V.T.I.C. Article 3.74,
55 refers to a policy of "accident and sickness

1 insurance." For consistency with modern usage, the
2 revised law substitutes "health" for "sickness."

3 (2) Section 1(b)(3), V.T.I.C. Article 3.74,
4 refers to a "hospital service corporation" subject to
5 V.T.I.C. Chapter 20, revised as Chapter 842 of this
6 code. The term most frequently used to refer to such a
7 corporation is "group hospital service corporation."
8 Consequently, the revised law substitutes "group
9 hospital service corporation" for "hospital service
10 corporation" for consistency of terminology in this
11 code.

12 (3) Section 1(b)(3), V.T.I.C. Article 3.74,
13 refers to "Section 1876 or Section 1833 of the Federal
14 Social Security Act (42 U.S.C.A. Section 1395, et
15 seq.)." The correct reference for those sections is
16 "Section 1833 or 1876, Social Security Act (42 U.S.C.
17 Section 1395l or 1395mm)," and the revised law is
18 drafted accordingly.

19 (4) Section 1(b)(3), V.T.I.C. Article 3.74,
20 refers to the State Board of Insurance. Chapter 685,
21 Acts of the 73rd Legislature, Regular Session, 1993,
22 abolished the board and transferred its functions to
23 the commissioner of insurance and the Texas Department
24 of Insurance. Throughout this chapter, references to
25 the board have been changed appropriately.

26 Revised Law

27 Sec. 1652.003. APPLICABILITY OF CHAPTER. This chapter
28 applies to an individual or group Medicare supplement benefit plan
29 delivered or issued for delivery in this state and, regardless of
30 the place where the plan was delivered or issued for delivery, a
31 certificate that was issued under a group Medicare supplement
32 benefit plan and delivered or issued for delivery in this state, if
33 the plan or certificate is issued by:

34 (1) a capital stock insurance company, including a

1 life, health and accident, and general casualty insurance company;

2 (2) a mutual life insurance company;

3 (3) a mutual assessment life insurance company,
4 including a statewide mutual assessment company, local mutual aid
5 association, and burial association;

6 (4) a mutual or mutual assessment association of any
7 kind, including an association subject to Section 887.102;

8 (5) a mutual insurance company other than a life
9 insurance company;

10 (6) a mutual or natural premium life or casualty
11 insurance company;

12 (7) a fraternal benefit society;

13 (8) a Lloyd's plan;

14 (9) a reciprocal or interinsurance exchange;

15 (10) a nonprofit hospital, medical, or dental service
16 corporation, including a corporation operating under Chapter 842;

17 (11) a stipulated premium company;

18 (12) another insurer that by law is required to be
19 authorized by the department; or

20 (13) a health maintenance organization operating
21 under Chapter 843, to the extent required by federal law. (V.T.I.C.
22 Art. 3.74, Secs. 1(a) (part), (b)(2).)

23 Source Law

24 Art. 3.74

25 Sec. 1. (a) Scope of Article. Notwithstanding
26 Section 2(b)(5) of Article 1.14-1 of this code, this
27 article applies to and governs group and individual
28 medicare supplement policies delivered or issued for
29 delivery in this state and certificates issued under
30 group medicare supplement policies that have been
31 delivered or issued for delivery in this state if those
32 policies or certificates are issued by capital stock
33 companies, including but not limited to life, health
34 and accident, and general casualty companies; mutual
35 life insurance companies; mutual assessment life
36 insurance companies, including but not limited to
37 statewide mutual assessment corporations, local
38 mutual aids, and burial associations; mutual and
39 mutual assessment associations of all kinds and types,
40 including but not limited to associations subject to
41 Article 14.17 of this code; mutual insurance companies
42 other than life; mutual or natural premium life or
43 casualty insurance companies; fraternal benefit
44 societies; Lloyds; reciprocal or inter-insurance

1 exchanges; nonprofit hospital, medical, or dental
2 service corporations, including but not limited to
3 companies subject to Chapter 20 of this code;
4 stipulated premium insurance companies; or any other
5 insurer which by law is required to be licensed by the
6 State Board of Insurance; and, to the extent required
7 by federal law, health maintenance organizations
8 subject to the Texas Health Maintenance Organization
9 Act (Chapter 20A, Vernon's Texas Insurance Code);
10 provided, that

11 [(b)]

12 (2) "Certificate" means, for the purposes
13 of this article, any certificate issued under a group
14 medicare supplement policy, which certificate has been
15 delivered or issued for delivery in this state
16 regardless of the place where the policy was delivered
17 or issued for delivery.

18 Revisor's Note

19 (1) Section 1(a), V.T.I.C. Article 3.74, states
20 that "[n]otwithstanding Section 2(b)(5) of Article
21 1.14-1 of this code, this article applies to and
22 governs" certain policies. The revised law omits the
23 reference to Section 2(b)(5), V.T.I.C. Article 1.14-1,
24 as unnecessary. Section 2(b)(5), revised as Section
25 101.053(b)(5) of this code, describes the types of
26 transactions that are not considered to be the
27 business of insurance and therefore are not regulated
28 under general Insurance Code provisions relating to
29 insurance regulation. Because V.T.I.C. Article 3.74,
30 revised as this chapter, provides explicit authority
31 to regulate Medicare supplement benefit plans,
32 including plans that otherwise would be described by
33 Section 101.053(b)(5), it is not necessary to negate
34 the effect of Section 2(b)(5), V.T.I.C. Article
35 1.14-1. The revised law omits "and governs" as
36 unnecessary because the language does not add to the
37 clear meaning of the law.

38 (2) Section 1(a), V.T.I.C. Article 3.74, refers
39 to companies and associations, "including but not
40 limited to" certain companies and associations. The
41 revised law omits "but not limited to" as unnecessary
42 because Section 311.005(13), Government Code (Code

1 Construction Act), and Section 312.011(19),
2 Government Code, provide that "includes" and
3 "including" are terms of enlargement and not of
4 limitation and do not create a presumption that
5 components not expressed are excluded.

6 (3) Section 1(a), V.T.I.C. Article 3.74, refers
7 to any other insurer required by law to be "licensed"
8 by the State Board of Insurance (now the Texas
9 Department of Insurance). The revised law substitutes
10 "authorized" for "licensed" for consistency of
11 terminology within this code.

12 Revised Law

13 Sec. 1652.004. CONSTRUCTION OF CHAPTER. (a) This chapter
14 may not be construed to enlarge the powers of an entity described by
15 Section 1652.003.

16 (b) This chapter controls to the extent of any conflict with
17 another provision of this code. (V.T.I.C. Art. 3.74, Secs. 1(a)
18 (part), 7 (part).)

19 Source Law

20 Sec. 1. (a) . . . this article shall not be
21 construed to enlarge the powers of any of the
22 enumerated companies.

23 Sec. 7. . . . in the event of any conflict
24 between the provisions of this article and any other
25 provisions of the Insurance Code, the provisions of
26 this article control to the extent of such conflict.

27 Revisor's Note

28 The revised law omits as unnecessary that part of
29 Section 7, V.T.I.C. Article 3.74, relating to the
30 cumulative effect of that article. An accepted
31 general principle of statutory construction requires a
32 statute to be given cumulative effect with other
33 statutes unless it provides otherwise or unless the
34 statutes are in conflict. The general principle
35 applies to this revision. The omitted law reads:

36 Sec. 7. The provisions of this
37 article are cumulative of all other law, but

1

2 Revised Law

3 Sec. 1652.005. RULES NECESSARY FOR CERTIFICATION. In
4 addition to other rules required or authorized by this chapter, the
5 commissioner shall adopt reasonable rules necessary and proper to
6 carry out this chapter, including rules adopted in accordance with
7 federal law relating to the regulation of Medicare supplement
8 benefit plan coverage that are necessary for this state to obtain or
9 retain certification as a state with an approved regulatory
10 program. (V.T.I.C. Art. 3.74, Sec. 10.)

11 Source Law

12 Sec. 10. In addition to other rules required or
13 authorized by this article, the State Board of
14 Insurance shall adopt rules in accordance with federal
15 law applicable to the regulation of medicare
16 supplement insurance coverage that are necessary for
17 the state to obtain or retain certification as a state
18 with an approved regulatory program under 42 U.S.C.
19 Section 1395ss and any other reasonable rules that are
20 necessary and proper to carry out this article.

21 [Sections 1652.006-1652.050 reserved for expansion]

22 SUBCHAPTER B. BENEFITS

23 Revised Law

24 Sec. 1652.051. MINIMUM STANDARDS. (a) The commissioner
25 shall adopt reasonable rules to establish specific standards for
26 provisions in Medicare supplement benefit plans and standards for
27 facilitating comparisons of different Medicare supplement benefit
28 plans. The standards are in addition to and must be in accordance
29 with:

30 (1) applicable laws of this state, including Chapters
31 842 and 1201;

32 (2) applicable federal law, rules, regulations, and
33 standards; and

34 (3) any model rules and regulations required by
35 federal law, including Section 1882, Social Security Act (42 U.S.C.
36 Section 1395ss).

37 (b) The standards may include provisions relating to:

38 (1) terms of renewability;

- 1 (2) initial and subsequent conditions of eligibility;
- 2 (3) nonduplication of coverage;
- 3 (4) probationary periods;
- 4 (5) benefit limitations, exceptions, and reductions;
- 5 (6) elimination periods;
- 6 (7) requirements for replacement;
- 7 (8) recurrent conditions;
- 8 (9) definitions of terms; and
- 9 (10) exclusions required by state or federal law.

10 (c) The commissioner may adopt reasonable rules that
11 specifically prohibit benefit plan provisions that:

12 (1) are not otherwise specifically authorized by
13 statute; and

14 (2) the commissioner determines are unjust, unfair, or
15 unfairly discriminatory to a person who is covered or proposed for
16 coverage.

17 (d) Rules adopted under this section must include
18 requirements that are at least equal to those required by federal
19 law, rules, regulations, and standards, including Section 1882,
20 Social Security Act (42 U.S.C. Section 1395ss). (V.T.I.C. Art.
21 3.74, Secs. 2(c), (d), (f).)

22 Source Law

23 (c) The State Board of Insurance shall issue
24 reasonable rules to establish specific standards for
25 provisions of medicare supplement policies and
26 standards for facilitating comparison among the
27 medicare supplement products of the insurer or entity
28 offering such medicare supplement products. Such
29 standards shall be in addition to and in accordance
30 with applicable laws of this state, including but not
31 limited to Subchapter G of Chapter 3, Chapter 20 of
32 this Code, and applicable federal law, rules,
33 regulations, and standards and any model rules and
34 regulations required by 42 U.S.C. Section 1395ss and
35 other federal law and may cover but shall not be
36 limited to:

- 37 (1) terms of renewability;
- 38 (2) initial and subsequent conditions of
39 eligibility;
- 40 (3) nonduplication of coverage;
- 41 (4) probationary periods;
- 42 (5) benefit limitations, exceptions, and
43 reductions;
- 44 (6) elimination periods;
- 45 (7) requirements for replacement;

1 (8) recurrent conditions;
2 (9) definitions of terms; and
3 (10) exclusions required by state or
4 federal law.

5 (d) The State Board of Insurance may issue
6 reasonable rules that specify prohibited provisions
7 not otherwise specifically authorized by statute
8 which, in the opinion of the State Board of Insurance,
9 are unjust, unfair, or unfairly discriminatory to any
10 person insured or proposed for coverage under a
11 medicare supplement policy.

12 (f) The rules issued by the State Board of
13 Insurance under this section must include requirements
14 that are at least equal to those required by federal
15 law, rules, regulations, and standards, including 42
16 U.S.C. Section 1395ss.

17 Revisor's Note

18 (1) Section 2(c), V.T.I.C. Article 3.74, refers
19 to laws, "including but not limited to" certain laws.
20 The revised law omits "but not limited to" for the
21 reason stated in Revisor's Note (2) to Section
22 1652.003.

23 (2) Section 2(c), V.T.I.C. Article 3.74, refers
24 to standards that "may cover but shall not be limited
25 to" certain terms. The revised law substitutes
26 "include" for "cover" because the terms are synonymous
27 in context and omits "but shall not be limited to" for
28 the reason stated in Revisor's Note (2) to Section
29 1652.003.

30 Revised Law

31 Sec. 1652.052. MINIMUM STANDARDS FOR BENEFITS AND CLAIM
32 PAYMENTS. (a) The commissioner shall adopt reasonable rules to
33 establish minimum standards for benefits and claim payments under
34 Medicare supplement benefit plans.

35 (b) The standards for benefits and claim payments must
36 include the requirements for certification of Medicare supplement
37 benefit plans prescribed by Section 1882, Social Security Act (42
38 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Sec. 3.)

39 Source Law

40 Sec. 3. (a) The State Board of Insurance shall
41 issue reasonable rules to establish minimum standards
42 for benefits and claim payments under medicare
43 supplement policies.

1 (b) Minimum standards for benefits and claim
2 payments shall include the requirements for
3 certification of medicare supplement policies as
4 provided by 42 U.S.C. Section 1395ss.

5 Revised Law

6 Sec. 1652.053. DUPLICATE BENEFITS PROHIBITED. A Medicare
7 supplement benefit plan or certificate in force in this state may
8 not contain benefits that duplicate benefits provided by Medicare.
9 (V.T.I.C. Art. 3.74, Sec. 2(a).)

10 Source Law

11 Sec. 2. (a) No medicare supplement insurance
12 policy or certificate in force in this state shall
13 contain benefits that duplicate benefits provided by
14 medicare.

15 Revised Law

16 Sec. 1652.054. BASIC PLAN. An entity described by Section
17 1652.003 that offers for sale in this state a Medicare supplement
18 benefit plan must offer a basic Medicare supplement benefit plan
19 that:

20 (1) provides only those benefits common to all
21 Medicare supplement benefit plans; and

22 (2) meets but does not exceed the minimum standards of
23 benefits for Medicare supplement benefit plans adopted by the
24 commissioner and authorized by Section 1882, Social Security Act
25 (42 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Sec. 2(b)
26 (part).)

27 Source Law

28 (b) Any insurer or other entity designated in
29 Section 1(a) of this article that offers for sale in
30 this state a medicare supplement insurance policy must
31 offer a basic medicare supplement policy that provides
32 only those benefits common to all medicare supplement
33 policies, and that meets, but does not exceed the
34 minimum standards of benefits for medicare supplement
35 policies authorized by 42 U.S.C. Section 1395ss and
36 adopted by the board. . . .

37 Revisor's Note

38 Section 2(b), V.T.I.C. Article 3.74, refers to an
39 "insurer or other entity" designated under Section
40 1(a) of that article. The revised law substitutes
41 "entity" for "insurer or other entity" because the

1 terms are synonymous in context. Similar changes are
2 made throughout this chapter.

3 Revised Law

4 Sec. 1652.055. ADDITIONAL BENEFITS. (a) In addition to
5 the basic Medicare supplement benefit plan described by Section
6 1652.054, an entity may offer additional Medicare supplement
7 benefit plans for sale in this state.

8 (b) The combination of benefits provided by an additional
9 plan must conform to one of the benefit packages adopted by the
10 commissioner and authorized by Section 1882, Social Security Act
11 (42 U.S.C. Section 1395ss).

12 (c) The commissioner by rule shall provide for the approval
13 of new or innovative benefits that may be provided in a plan other
14 than the basic plan and that otherwise comply with this subchapter.
15 The benefits must:

16 (1) be offered in a manner consistent with the goal of
17 Medicare supplement benefit plan simplification; and

18 (2) meet the requirements prescribed by Section 1882,
19 Social Security Act (42 U.S.C. Section 1395ss). (V.T.I.C. Art.
20 3.74, Sec. 2(b) (part).)

21 Source Law

22 (b) . . . In addition to this basic medicare
23 supplement insurance policy, any such insurer or other
24 entity may offer for sale in this state additional
25 medicare supplement policies. The combination of
26 benefits provided by the additional policies must
27 conform to one of the benefit packages authorized by 42
28 U.S.C. Section 1395ss and adopted by the board. The
29 board by rule shall provide for the approval of new or
30 innovative benefits that may be provided in a policy
31 other than the basic policy and that otherwise comply
32 with this section. The new or innovative benefits
33 shall be offered in a manner consistent with the goal
34 of medicare supplement policy simplification and shall
35 meet the requirements set forth in 42 U.S.C. Section
36 1395ss.

37 Revised Law

38 Sec. 1652.056. COVERAGE FOR MAMMOGRAPHY. (a) In this
39 section, "low-dose mammography" means the x-ray examination of the
40 breast using equipment dedicated specifically for mammography,
41 including the x-ray tube, filter, compression device, screens,

1 films, and cassettes, with an average radiation exposure delivery
2 of less than one rad mid-breast, with two views for each breast.

3 (b) Each Medicare supplement benefit plan must include
4 coverage for an annual screening by low-dose mammography for the
5 presence of occult breast cancer.

6 (c) The coverage for the annual screening may not be less
7 favorable than coverage for other radiological examinations and
8 must be subject to the same dollar limits, deductibles, and
9 coinsurance factors. (V.T.I.C. Art. 3.74, Sec. 3A.)

10 Source Law

11 Sec. 3A. (a) In this section, "low-dose
12 mammography" means the X-ray examination of the breast
13 using equipment dedicated specifically for
14 mammography, including the X-ray tube, filter,
15 compression device, screens, films, and cassettes,
16 with an average radiation exposure delivery of less
17 than one rad mid-breast, with two views for each
18 breast.

19 (b) Each Medicare supplement policy delivered,
20 issued for delivery, or renewed in this state must
21 include coverage for an annual screening by low-dose
22 mammography for the presence of occult breast cancer
23 within the provisions of the policy that is not less
24 favorable than for other radiological examinations and
25 subject to the same dollar limits, deductibles, and
26 co-insurance factors.

27 Revised Law

28 Sec. 1652.057. WAIVER OF WAITING PERIOD. (a) An entity
29 that delivers or issues for delivery in this state a Medicare
30 supplement benefit plan or certificate that replaces a Medicare
31 supplement benefit plan or certificate shall give credit for the
32 satisfaction or partial satisfaction of any waiting period,
33 elimination period, or probationary period for a preexisting
34 condition that has been satisfied under the plan being replaced.

35 (b) A replacement plan that clearly provides a new or
36 additional benefit may include appropriate and clearly stated
37 periods as a condition for payment of the new or additional benefit.
38 (V.T.I.C. Art. 3.74, Sec. 8.)

39 Source Law

40 Sec. 8. An insurer or other entity that delivers
41 or issues for delivery a medicare supplement policy or
42 certificate in this state that replaces an existing
43 medicare supplement policy or certificate shall give

1 credit for the satisfaction or partial satisfaction of
2 any waiting periods, elimination periods, and
3 probationary periods that are applicable to
4 preexisting conditions and that have already been
5 satisfied under the policy being replaced. Any new or
6 additional benefits that are clearly set forth in the
7 replacement policy may include appropriate clearly
8 stated time periods as a condition of payment for such
9 new or additional benefits.

10 Revised Law

11 Sec. 1652.058. COVERAGE FOR PREEXISTING CONDITION. (a) A
12 Medicare supplement benefit plan may not contain a provision that
13 excludes coverage for a claim for losses incurred more than six
14 months after the effective date of coverage for a preexisting
15 condition.

16 (b) A Medicare supplement benefit plan may not define a
17 preexisting condition more restrictively than a condition for which
18 medical advice was given or treatment was recommended by or
19 received from a physician within six months before the effective
20 date of coverage. (V.T.I.C. Art. 3.74, Sec. 2(e).)

21 Source Law

22 (e) Notwithstanding any other provisions of the
23 law, a medicare supplement policy may not deny a claim
24 for losses incurred more than six months from the
25 effective date of coverage for a preexisting
26 condition. Such policy may not define a preexisting
27 condition more restrictively than a condition for
28 which medical advice was given or treatment was
29 recommended by or received from a physician within six
30 months before the effective date of coverage.

31 [Sections 1652.059-1652.100 reserved for expansion]

32 SUBCHAPTER C. LOSS RATIO STANDARDS

33 Revised Law

34 Sec. 1652.101. LOSS RATIO STANDARDS. (a) A Medicare
35 supplement benefit plan must return to a plan holder benefits that
36 are reasonable in relation to the premium charged.

37 (b) The commissioner shall adopt reasonable rules to
38 establish minimum loss ratio standards for Medicare supplement
39 benefit plans. The standards must be established:

40 (1) on the basis of incurred claims experience and
41 earned premiums for the entire period for which rates are computed
42 to provide coverage;

1 (2) in accordance with accepted actuarial principles
2 and practices; and

3 (3) to the extent necessary for the state to obtain or
4 retain certification as a state with an approved regulatory
5 program. (V.T.I.C. Art. 3.74, Secs. 4(a), (d).)

6 Source Law

7 Sec. 4. (a) Medicare supplement policies shall
8 return to holders of a medicare supplement policy
9 benefits which are reasonable in relation to the
10 premium charged. The State Board of Insurance shall
11 issue reasonable rules to establish minimum standards
12 for loss ratios of medicare supplement policies on the
13 basis of incurred claims experience and earned
14 premiums for the entire period for which rates are
15 computed to provide coverage and in accordance with
16 accepted actuarial principles and practices.

17 (d) The State Board of Insurance shall issue
18 reasonable rules providing loss ratio standards
19 applicable to rates charged for medicare supplement
20 policies to the extent necessary for the state to
21 obtain or retain certification as a state with an
22 approved regulatory program under 42 U.S.C. Section
23 1395ss.

24 Revised Law

25 Sec. 1652.102. FILING REQUIREMENTS. (a) Annually, each
26 entity providing Medicare supplement benefit plans in this state
27 shall file with the department the entity's rates, rating schedule,
28 and supporting documentation demonstrating that:

29 (1) the entity is complying with the applicable loss
30 ratio standards of this state; and

31 (2) the actual and expected losses in relation to
32 premiums comply with the requirements of this subchapter and the
33 rules adopted by the commissioner.

34 (b) The documentation required by Subsection (a) must
35 include a report of the ratio of incurred losses to covered premiums
36 for the preceding calendar year, illustrated by calendar year of
37 issue.

38 (c) The commissioner may adopt rules relating to filing
39 requirements for rates, rating schedules, and loss ratios.
40 (V.T.I.C. Art. 3.74, Secs. 4(b), (c).)

1 Source Law

2 (b) Every entity providing medicare supplement
3 policies or benefits in this state shall file annually
4 its rates, rating schedule, and supporting
5 documentation demonstrating that it is in compliance
6 with the applicable loss ratio standards of this
7 state. The supporting documentation must include a
8 report of the ratio of incurred losses to covered
9 premiums for the preceding calendar year, illustrated
10 by calendar year of issue. The board may adopt rules
11 relating to filing requirements for rates, rating
12 schedules, and loss ratios.

13 (c) All filings of rates, rating schedules, and
14 loss ratios must demonstrate that the actual and
15 expected losses in relation to premiums comply with
16 the requirements of this section and rules adopted by
17 the board.

18 Revised Law

19 Sec. 1652.103. REVIEW OF PREMIUM INCREASES. (a) The
20 commissioner by rule shall provide a process for reviewing and
21 approving or disapproving a proposed premium increase relating to a
22 Medicare supplement benefit plan.

23 (b) The rules must comply with federal law, including
24 Section 1882, Social Security Act (42 U.S.C. Section 1395ss).
25 (V.T.I.C. Art. 3.74, Sec. 4(f).)

26 Source Law

27 (f) The board by rule shall provide a process
28 for review and approval or disapproval of proposed
29 premium increases with respect to medicare supplement
30 policies or benefits. Any rules adopted by the board
31 under this subsection must comply with 42 U.S.C.
32 Section 1395ss and other federal law.

33 Revised Law

34 Sec. 1652.104. BENEFIT CHANGES. (a) Before the date on
35 which a Medicare benefit change required by federal law takes
36 effect, each entity providing in this state a Medicare supplement
37 benefit plan existing on the effective date of the change shall file
38 with the commissioner, in accordance with Chapter 1701:

39 (1) each appropriate premium adjustment necessary to
40 produce the loss ratios originally anticipated for the applicable
41 plan, accompanied by any supporting documents necessary to justify
42 the adjustment; and

43 (2) each appropriate rider, endorsement, or plan form
44 necessary to modify the coverage so as to eliminate benefit

1 duplications with Medicare.

2 (b) A rider, endorsement, or plan form required by
3 Subsection (a) must provide a clear description of the Medicare
4 supplement benefits provided by the plan. (V.T.I.C. Art. 3.74,
5 Sec. 4(e).)

6 Source Law

7 (e) Before the effective date of any medicare
8 benefit changes required by federal law as applicable
9 to existing policies, every insurer, health care
10 service plan, or other entity providing medicare
11 supplement insurance or contracts in this state shall
12 file with the commissioner, in accordance with Article
13 3.42 of this code:

14 (1) appropriate premium adjustments
15 necessary to produce loss ratios as originally
16 anticipated for the applicable policies or contracts,
17 and such supporting documents as necessary to justify
18 the adjustment shall accompany the filing; and

19 (2) appropriate riders, endorsements, or
20 policy forms needed to accomplish the medicare
21 supplement insurance modifications necessary to
22 eliminate benefit duplications with medicare.

23 Those riders, endorsements, or policy forms shall
24 provide a clear description of the medicare supplement
25 benefits provided by the policy or contract.

26 Revised Law

27 Sec. 1652.105. REPORTING LOSS RATIO INFORMATION TO
28 SECRETARY OF HEALTH AND HUMAN SERVICES. To the extent necessary
29 for this state to obtain or retain certification as a state with an
30 approved regulatory program, the department shall comply with
31 federal requirements relating to periodic reporting of loss ratio
32 information to the secretary of health and human services, based on
33 a uniform methodology, as authorized by federal law. (V.T.I.C.
34 Art. 3.74, Sec. 4(g).)

35 Source Law

36 (g) The board shall comply with federal
37 requirements relating to periodical reporting on loss
38 ratio information to the Secretary of Health and Human
39 Services, based on uniform methodology for reporting
40 loss ratios, as authorized by federal law to the extent
41 necessary for this state to obtain or retain
42 certification as a state with an approved regulatory
43 program under 42 U.S.C. Section 1395ss.

1 [Sections 1652.106-1652.150 reserved for expansion]

2 SUBCHAPTER D. CONSUMER INFORMATION AND NOTICE

3 Revised Law

4 Sec. 1652.151. RULES RELATING TO DISCLOSURE. The rules
5 adopted under Sections 1652.152, 1652.153, and 1652.154 must
6 include provisions and requirements that are at least equal to
7 those required by federal law, including the rules, regulations,
8 and standards adopted under Section 1882, Social Security Act (42
9 U.S.C. Section 1395ss). (V.T.I.C. Art. 3.74, Secs. 5(b) (part),
10 (f).)

11 Source Law

12 (b) . . . The rules adopted by the board
13 governing the outline of coverage must include
14 provisions at least equal to those required by rules,
15 regulations, and standards adopted under 42 U.S.C.
16 Section 1395ss or required by other federal law.

17 (f) Any rules adopted by the board under this
18 section must include requirements that are at least
19 equal to those required by rules, regulations, and
20 standards adopted under 42 U.S.C. Section 1395ss or
21 required by other federal law.

22 Revised Law

23 Sec. 1652.152. OUTLINE OF COVERAGE. (a) To provide for
24 full and fair disclosure in the sale of Medicare supplement benefit
25 plans, a Medicare supplement benefit plan or certificate may not be
26 delivered or issued for delivery in this state unless an outline of
27 coverage that complies with this section is delivered to the
28 applicant when the applicant applies for the coverage.

29 (b) The commissioner by rule shall prescribe the format and
30 content of the outline of coverage required by Subsection (a). The
31 rules must address the style, arrangement, and overall appearance
32 of the outline of coverage, including the size, color, and
33 prominence of type and the arrangement of text and captions.
34 (V.T.I.C. Art. 3.74, Secs. 5(a), (b) (part).)

35 Source Law

36 Sec. 5. (a) In order to provide for full and
37 fair disclosure in the sale of medicare supplement
38 policies, no medicare supplement policy or certificate
39 shall be delivered or issued for delivery in this state
40 unless an outline of coverage complying with the

1 requirements of this section is delivered to the
2 applicant at the time application is made.

3 (b) The State Board of Insurance by rule shall
4 prescribe the format and content of the outline of
5 coverage required by Subsection (a) of this section.
6 For purposes of this section, "format" means style,
7 arrangements, and overall appearance, including such
8 items as the size, color, and prominence of type and
9 the arrangement of text and captions. . . .

10 Revised Law

11 Sec. 1652.153. INFORMATIONAL BROCHURE. (a) The
12 commissioner by rule may prescribe a standard form and the contents
13 of an informational brochure intended to improve the ability of an
14 individual eligible for Medicare to understand Medicare and to
15 select the most appropriate Medicare supplement coverage.

16 (b) Except as provided by Subsection (c), the commissioner
17 by rule may require that the informational brochure be provided to
18 an individual eligible for Medicare concurrently with delivery of
19 the outline of coverage.

20 (c) If the plan is a direct response Medicare supplement
21 benefit plan, the commissioner by rule may require that the
22 informational brochure be provided on request to an individual
23 eligible for Medicare at any time not later than the time the plan
24 is delivered. (V.T.I.C. Art. 3.74, Sec. 5(c).)

25 Source Law

26 (c) The State Board of Insurance may prescribe
27 by rule a standard form and the contents of an
28 informational brochure for persons eligible for
29 medicare which is intended to improve the buyer's
30 ability to select the most appropriate coverage and
31 improve the buyer's understanding of medicare. Except
32 in the case of direct response medicare supplement
33 policies, the State Board of Insurance may require by
34 rule that the informational brochure be provided to
35 any prospective insureds eligible for medicare
36 concurrently with delivery of the outline of coverage.
37 With respect to direct response medicare supplement
38 policies, the State Board of Insurance may require by
39 rule that the prescribed brochure be provided upon
40 request to any prospective insureds eligible for
41 medicare but in no event later than the time of policy
42 delivery.

43 Revisor's Note

44 Section 5(c), V.T.I.C. Article 3.74, refers to
45 "prospective insureds eligible for medicare." The
46 revised law omits "prospective insureds" as redundant

1 because an individual eligible for Medicare is also a
2 "prospective insured."

3 Revised Law

4 Sec. 1652.154. NOTICE RELATING TO OTHER TYPES OF
5 COVERAGE. (a) The commissioner may adopt reasonable rules for
6 captions or notice requirements for each accident and health
7 insurance policy, subscriber contract, or evidence of coverage sold
8 to an individual eligible for Medicare that are determined to be in
9 the public interest and designed to inform the individual that a
10 particular coverage is not a Medicare supplement benefit plan.
11 This subsection does not apply to:

- 12 (1) a Medicare supplement benefit plan;
13 (2) a disability income policy;
14 (3) a basic, catastrophic, or major medical expense
15 policy;
16 (4) a single premium nonrenewable policy; or
17 (5) another policy, contract, or subscriber contract
18 described by Section 1652.002(b)(1) or (2).

19 (b) The commissioner may adopt reasonable rules to govern
20 the full and fair disclosure of information relating to replacing
21 an accident and health insurance policy, a subscriber contract, or
22 a certificate by an individual eligible for Medicare. (V.T.I.C.
23 Art. 3.74, Secs. 5(d), (e).)

24 Source Law

25 (d) The State Board of Insurance may promulgate
26 reasonable rules for captions or notice requirements
27 determined to be in the public interest and designed to
28 inform prospective insureds, subscribers, or
29 enrollees that particular coverages are not medicare
30 supplement coverages for all accident and sickness
31 insurance policies or subscriber contracts or
32 evidences of coverage sold to persons eligible for
33 medicare, other than:

- 34 (1) medicare supplement policies;
35 (2) disability income policies;
36 (3) basic, catastrophic, or major medical
37 expense policies;
38 (4) single premium nonrenewable policies;
39 or
40 (5) other policies, contracts, or
41 subscriber contracts as specified in Paragraphs (A)
42 and (B) of Subsection (b) of Section 1 of this article.
43 (e) The State Board of Insurance may further

1 promulgate reasonable rules to govern the full and
2 fair disclosure of the information in connection with
3 the replacement of accident and sickness policies,
4 subscriber contracts, or certificates by persons
5 eligible for medicare.

6 Revisor's Note

7 (1) Section 5(d), V.T.I.C. Article 3.74, refers
8 to "prospective insureds, subscribers, or enrollees."
9 The revised law substitutes "individual eligible for
10 Medicare" for consistency of terminology in this
11 chapter. An individual eligible for Medicare is also a
12 "prospective insured, subscriber, or enrollee."

13 (2) Sections 5(d) and (e), V.T.I.C. Article
14 3.74, refer to "accident and sickness" insurance
15 policies. The revised law substitutes "health" for
16 "sickness" for the reason stated in Revisor's Note (1)
17 to Section 1652.002.

18 (3) Section 5(d)(5), V.T.I.C. Article 3.74,
19 refers to policies, contracts, or subscriber contracts
20 as specified in "Paragraphs (A) and (B) of Subsection
21 (b) of Section 1 of this article." It is apparent from
22 the context of the source law that the correct
23 cross-reference is Sections 1(b)(3)(A) and (B),
24 revised as Sections 1652.002(b)(1) and (2), and the
25 revised law is drafted accordingly.

26 Revised Law

27 Sec. 1652.155. RIGHT TO RETURN FOR REFUND; NOTICE. (a) If
28 an applicant is not satisfied for any reason after examining a
29 Medicare supplement benefit plan document or certificate, the
30 applicant is entitled to receive a refund of the premium if the
31 applicant returns the document or certificate not later than the
32 30th day after the date it is delivered.

33 (b) The entity issuing the plan or certificate shall refund
34 the premium directly to the applicant in a timely manner.

35 (c) A Medicare supplement benefit plan or certificate must
36 have a notice stating the substance prescribed by Subsection (a)

1 prominently printed on the first page of or attached to the plan or
2 certificate. (V.T.I.C. Art. 3.74, Sec. 6.)

3 Source Law

4 Sec. 6. Medicare supplement policies or
5 certificates shall have a notice prominently printed
6 on the first page of such policy or certificate or
7 attached thereto stating in substance that the
8 applicant shall have the right to return such policy or
9 certificate within 30 days of its delivery and to have
10 the premium refunded if, after examination of such
11 policy or certificate, the applicant is not satisfied
12 for any reason. A refund made pursuant to this section
13 must be paid directly to the applicant in a timely
14 manner by the entity issuing the policy or
15 certificate.

16 Revised Law

17 Sec. 1652.156. ADVERTISING FILING REQUIREMENTS. (a) The
18 commissioner shall adopt reasonable rules to require each entity
19 described by Section 1652.003 to file with the department a copy of
20 any advertisement relating to Medicare supplement benefit plans
21 that the entity intends to use in this state. The rules must
22 require that the entity file the copy not later than the 60th day
23 before the date of intended use.

24 (b) At the expiration of the 60-day period provided by
25 Subsection (a), an advertisement filed in accordance with that
26 subsection is considered acceptable, unless before the end of that
27 60-day period the department notifies the entity of the
28 advertisement's nonacceptance.

29 (c) An entity may not use an advertisement for Medicare
30 supplement benefit plans that does not comply with state law,
31 including department rules. (V.T.I.C. Art. 3.74, Sec. 9.)

32 Source Law

33 Sec. 9. (a) The State Board of Insurance shall
34 issue reasonable rules to require each entity
35 designated in Section 1(a) of this article that
36 delivers or issues for delivery in this state a group
37 or individual medicare supplement policy or
38 certificate to file with the State Board of Insurance,
39 not later than the 60th day before the date of the
40 intended use of the advertisement, a copy of the
41 advertisement that is intended for use in this state
42 and that relates to medicare supplement insurance.
43 The advertisement must comply with applicable law of
44 this state and rules of the State Board of Insurance.

45 (b) At the expiration of the 60-day period
46 provided by Subsection (a) of this section, any

1 advertisement that is filed under that subsection
2 shall be deemed acceptable, unless before the end of
3 that 60-day period the board has notified the entity of
4 its nonacceptance.

5 (c) An entity may not use an advertisement for
6 medicare supplement insurance that does not comply
7 with this state's law and the board's rules.

8 Revisor's Note

9 Section 9(a), V.T.I.C. Article 3.74, refers to an
10 "entity designated in Section 1(a) of this article
11 that delivers or issues for delivery in this state a
12 group or individual medicare supplement policy or
13 certificate." The revised law omits the reference to
14 "delivers or issues for delivery in this state a group
15 or individual medicare supplement policy or
16 certificate" because an entity "designated" by Section
17 1(a), V.T.I.C. Article 3.74, revised as Section
18 1652.003, is by the terms of Section 1(a) such an
19 entity.

20 [Sections 1652.157-1652.200 reserved for expansion]

21 SUBCHAPTER E. AGENTS

22 Revised Law

23 Sec. 1652.201. INFORMATION PROVIDED TO AGENTS. (a) An
24 entity that offers a Medicare supplement benefit plan for sale in
25 this state shall provide to each agent authorized to sell that plan
26 information relating to:

27 (1) Medicare;

28 (2) the Medicare supplement benefit plans offered by
29 that entity; and

30 (3) the agent's ethical obligations to clients.

31 (b) The commissioner by rule may prescribe the information
32 that must be provided under this section. (V.T.I.C. Art. 3.74, Sec.
33 9A.)

34 Source Law

35 Sec. 9A. (a) Any insurer or other entity that
36 offers for sale in this state a medicare supplement
37 policy shall provide to each agent authorized to sell
38 its medicare supplement policies information related
39 to medicare, the medicare supplement policies offered
40 by the insurer or other entity, and the agent's ethical

1 obligations to clients.

2 (b) The State Board of Insurance may prescribe
3 by rule the information that must be provided under
4 this section.

5 Revised Law

6 Sec. 1652.202. PERMITTED COMPENSATION ARRANGEMENTS. (a)
7 The commissioner by rule shall limit the commission or other
8 compensation that may be paid to an agent for the sale of a Medicare
9 supplement benefit plan or certificate, including a replacement
10 plan or certificate.

11 (b) The rules must conform to, but may not be more
12 restrictive than, the requirements of federal law necessary for
13 this state to obtain or retain certification as a state with an
14 approved regulatory program. (V.T.I.C. Art. 3.74, Sec. 9B.)

15 Source Law

16 Sec. 9B. The board shall adopt rules limiting
17 the commission or other compensation that may be paid
18 to an agent for the sale of a medicare supplement
19 policy or certificate, including replacement policies
20 or certificates. Rules adopted by the board under this
21 section must conform to, but may not be more
22 restrictive than, the requirements of federal law that
23 must be met for the state to obtain or retain
24 certification as a state with an approved regulatory
25 program under 42 U.S.C. Section 1395ss.

26 TITLE 9. PROVISIONS APPLICABLE TO LIFE AND HEALTH COVERAGES

27 CHAPTER 1701. POLICY FORMS

28 TITLE 9. PROVISIONS APPLICABLE TO LIFE AND HEALTH COVERAGES

29 CHAPTER 1701. POLICY FORMS

30 SUBCHAPTER A. GENERAL PROVISIONS

31 Sec. 1701.001. DEFINITION 1386

32 Sec. 1701.002. APPLICABILITY OF CHAPTER TO FORMS OF CERTAIN
33 DOCUMENTS 1386

34 Sec. 1701.003. APPLICABILITY OF CHAPTER TO CERTAIN
35 INSURERS 1388

36 Sec. 1701.004. CONSTRUCTION OF CHAPTER. 1389

37 Sec. 1701.005. EXEMPTIONS 1389

38 [Sections 1701.006-1701.050 reserved for expansion]

39 SUBCHAPTER B. FILING REQUIREMENT

40 Sec. 1701.051. FILING REQUIRED 1390

1 Sec. 1701.052. FILE AND USE 1391
2 Sec. 1701.053. FILING FEE 1393
3 Sec. 1701.054. APPROVAL OF FORM 1394
4 Sec. 1701.055. DISAPPROVAL OF FORM OR WITHDRAWAL OF APPROVAL
5 OR EXEMPTION 1395
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7 Sec. 1701.057. WITHDRAWAL OF INDIVIDUAL ACCIDENT AND HEALTH
8 INSURANCE POLICY FORM APPROVAL 1397
9 Sec. 1701.058. RECONSIDERATION OF FORM. 1400
10 Sec. 1701.059. REPLACEMENT OR AMENDMENT OF DOCUMENT 1401
11 Sec. 1701.060. GENERAL RULEMAKING AUTHORITY. 1401

12 [Sections 1701.061-1701.100 reserved for expansion]

13 SUBCHAPTER C. SANCTIONS; APPLICABILITY OF OTHER LAWS

14 Sec. 1701.101. RESTITUTION 1404
15 Sec. 1701.102. LIMIT ON SANCTIONS. 1405
16 Sec. 1701.103. APPLICABILITY OF OTHER LAWS 1405

17 [Sections 1701.104-1701.150 reserved for expansion]

18 SUBCHAPTER D. CERTAIN POLICY APPLICATION FORMS

19 Sec. 1701.151. POLICY APPLICATION FORM FOR INDIVIDUAL
20 ACCIDENT AND HEALTH POLICY 1405

21 CHAPTER 1701. POLICY FORMS

22 SUBCHAPTER A. GENERAL PROVISIONS

23 Revised Law

24 Sec. 1701.001. DEFINITION. In this chapter, "use"
25 includes issue and deliver. (New.)

26 Revisor's Note

27 The definition of "use" is added for drafting
28 convenience, to avoid frequent, unnecessary
29 repetition of the substance of the definition, and to
30 ensure consistent use of terminology throughout the
31 chapter.

32 Revised Law

33 Sec. 1701.002. APPLICABILITY OF CHAPTER TO FORMS OF CERTAIN
34 DOCUMENTS. This chapter applies to the form of the following

1 document:

2 (1) a policy, contract, or certificate of:

3 (A) accident or health insurance, including
4 group accident or health insurance;

5 (B) medical or surgical insurance, including
6 group medical or surgical insurance;

7 (C) life or term insurance, including group life
8 or term insurance;

9 (D) endowment insurance;

10 (E) industrial life insurance; or

11 (F) fraternal benefit insurance;

12 (2) an annuity or pure endowment contract, including a
13 group annuity contract;

14 (3) an application attached or required to be attached
15 to the policy, contract, or certificate; or

16 (4) a rider or endorsement to be attached to, printed
17 on, or used in connection with the policy, contract, or
18 certificate. (V.T.I.C. Art. 3.42, Secs. (a) (part), (b) (part).)

19 Source Law

20 Art. 3.42. (a) [No] policy, contract or
21 certificate of life, term or endowment insurance,
22 group life or term insurance, industrial life
23 insurance, accident or health insurance, group
24 accident or health insurance, hospitalization
25 insurance, group hospitalization insurance, medical
26 or surgical insurance, group medical or surgical
27 insurance, or fraternal benefit insurance, and [no]
28 annuity or pure endowment contract or group annuity
29 contract, [shall be delivered, issued or used in this
30 state]

31 (b) [No] application form which is required to
32 be or is attached to the policy, contract or
33 certificate, and [no] rider or endorsement to be
34 attached to, printed upon or used in connection with
35 any policy, contract or certificate described by
36 Subsection (a) of this Article [shall be delivered,
37 issued or used in this state]

38 Revisor's Note

39 Section (a), V.T.I.C. Article 3.42, refers to
40 "hospitalization insurance" and "group
41 hospitalization insurance." The revised law omits the
42 quoted language because the meaning of those terms is

1 included in the meaning of "accident or health
2 insurance."

3 Revised Law

4 Sec. 1701.003. APPLICABILITY OF CHAPTER TO CERTAIN
5 INSURERS. (a) Except as provided by Subsection (b), this chapter
6 applies to any insurer that uses a document described by Section
7 1701.002 in this state, including:

8 (1) a life, accident, health, or casualty insurance
9 company;

10 (2) a mutual life insurance company;

11 (3) a mutual insurance company other than a mutual
12 life insurance company;

13 (4) a mutual or natural premium life insurance
14 company;

15 (5) a general casualty company;

16 (6) a Lloyd's plan;

17 (7) a reciprocal or interinsurance exchange;

18 (8) a fraternal benefit society; and

19 (9) a group hospital service corporation.

20 (b) This chapter does not apply to a society, company, or
21 other insurer whose activities are by statute exempt from
22 department control and that is entitled by statute to a certificate
23 from the department showing that exempt status. (V.T.I.C. Art.
24 3.42, Sec. (a) (part).)

25 Source Law

26 (a) [No policy, contract or certificate of life,
27 term or endowment insurance, group life or term
28 insurance, industrial life insurance, accident or
29 health insurance, group accident or health insurance,
30 hospitalization insurance, group hospitalization
31 insurance, medical or surgical insurance, group
32 medical or surgical insurance, or fraternal benefit
33 insurance, and no annuity or pure endowment contract
34 or group annuity contract, shall be delivered, issued
35 or used] in this state by a life, accident, health or
36 casualty insurance company, a mutual life insurance
37 company, mutual insurance company other than life,
38 mutual or natural premium life insurance company,
39 general casualty company, Lloyds, reciprocal or
40 interinsurance exchange, fraternal benefit society,
41 group hospitalization service or any other insurer,
42 [unless the form of said policy, contract or

1 certificate has been filed with the department as
2 provided by Subsections (c) and (d) of this Article.]
3 Provided, however, that this Article shall not apply
4 to any society, company or other insurer whose
5 activities are by statute exempt from the control of
6 the department and which is entitled by statute to an
7 exemption certificate from the department in evidence
8 of its exempt status;

9 Revisor's Note

10 Section (a), V.T.I.C. Article 3.42, refers to a
11 "group hospitalization service," meaning a
12 corporation operating under Chapter 842. The term
13 most frequently used to refer to such a corporation is
14 "group hospital service corporation." Consequently,
15 the revised law substitutes "group hospital service
16 corporation" for "group hospitalization service" to
17 provide for consistent use of terminology in this
18 code.

19 Revised Law

20 Sec. 1701.004. CONSTRUCTION OF CHAPTER. This chapter may
21 not be construed to enlarge the powers of an insurer subject to this
22 chapter. (V.T.I.C. Art. 3.42, Sec. (a) (part).)

23 Source Law

24 (a) . . . provided, further, that this Act
25 shall not be construed to enlarge the powers of any of
26 the insurers subject to this Article.

27 Revised Law

28 Sec. 1701.005. EXEMPTIONS. (a) This chapter does not
29 apply to a rider or endorsement that:

30 (1) is used at the request of the holder of a policy,
31 contract, or certificate subject to this chapter; and

32 (2) relates to:

33 (A) the manner of distribution of benefits under
34 the policy, contract, or certificate; or

35 (B) the reservation of rights and benefits under
36 the policy, contract, or certificate.

37 (b) The commissioner by written order may exempt a document
38 from the requirements of this chapter for the period the
39 commissioner considers proper if the commissioner determines that:

1 (1) this chapter may not practically be applied to the
2 document;

3 (2) the document's preparation, use, and meaning have
4 become routine or commonplace; or

5 (3) the filing and approval of the form of the document
6 are not desirable, appropriate, required, or necessary for the
7 protection of the public. (V.T.I.C. Art. 3.42, Secs. (b) (part),
8 (h) (part).)

9 Source Law

10 (b) . . . Provided, however, that this Article
11 shall not apply to riders or endorsements which relate
12 to the manner of distribution of benefits or to the
13 reservation of rights and benefits under such
14 policies, contracts and certificates, and which are
15 used at the request of the holder of the policy,
16 contract or certificate.

17 (h) The commissioner may, by written order,
18 exempt from the requirements of this Article for so
19 long as the commissioner considers proper, any
20 insurance document or form specified in such order, to
21 which in the commissioner's opinion this Article may
22 not practically be applied, the form's preparation,
23 use, and meaning have become routine or commonplace,
24 or the filing and approval of such form or document
25 are, in the commissioner's opinion, not desirable,
26 appropriate, required, or necessary for the protection
27 of the public. . . .

28 [Sections 1701.006-1701.050 reserved for expansion]

29 SUBCHAPTER B. FILING REQUIREMENT

30 Revised Law

31 Sec. 1701.051. FILING REQUIRED. (a) Except as provided
32 by Section 1701.005, an insurer may not use a document described by
33 Section 1701.002 in this state unless the form of the document is
34 filed with the department in accordance with this chapter.

35 (b) Except as provided by Section 1701.052, the insurer must
36 file the form of the document not later than the 60th day before the
37 date the document is used. (V.T.I.C. Art. 3.42, Secs. (a) (part),
38 (b) (part), (c) (part), (d) (part).)

39 Source Law

40 (a) No [policy, contract or certificate of life,
41 term or endowment insurance, group life or term
42 insurance, industrial life insurance, accident or
43 health insurance, group accident or health insurance,
44 hospitalization insurance, group hospitalization

1 insurance, medical or surgical insurance, group
2 medical or surgical insurance, or fraternal benefit
3 insurance, and] no [annuity or pure endowment contract
4 or group annuity contract,] shall be delivered, issued
5 or used in this state [by a life, accident, health or
6 casualty insurance company, a mutual life insurance
7 company, mutual insurance company other than life,
8 mutual or natural premium life insurance company,
9 general casualty company, Lloyds, reciprocal or
10 interinsurance exchange, fraternal benefit society,
11 group hospitalization service or any other insurer,]
12 unless the form of said policy, contract or
13 certificate has been filed with the department as
14 provided by Subsections (c) and (d) of this
15 Article. . . .

16 (b) No [application form which is required to be
17 or is attached to the policy, contract or certificate,
18 and] no [rider or endorsement to be attached to,
19 printed upon or used in connection with any policy,
20 contract or certificate described by Subsection (a) of
21 this Article] shall be delivered, issued or used in
22 this state by any insurer described by Subsection (a)
23 of this Article unless the form of said application,
24 rider or endorsement has been filed with the
25 department as provided by Subsections (c) and (d) of
26 this Article. . . .

27 (c) Each filing required under Subsection (a) or
28 (b) of this Article shall be made prior to any such
29 issuance, delivery or use of such form, contract or
30 policy. . . .

31 (d) In lieu of and as an alternative to such
32 filing being accompanied by such certification as
33 required by Subsection (c) of this Article, any such
34 filing required hereby shall be made not less than 60
35 days in advance of any such issuance, delivery, or use
36 of such form, and

37 Revised Law

38 Sec. 1701.052. FILE AND USE. (a) An insurer may use a
39 document described by Section 1701.002 immediately after the form
40 of the document is filed if the form, when filed, is accompanied by
41 a certification that meets the requirements of Subsection (b).

42 (b) The certification accompanying a form must:

43 (1) be signed by:

44 (A) an attorney licensed to practice law in this
45 state;

46 (B) an actuary familiar with the requirements of
47 this code and applicable rules adopted under this code;

48 (C) the chief executive officer of the insurer;
49 or

50 (D) an individual designated by the chief
51 executive officer of the insurer; and

52 (2) affirm that:

1 (A) the certification is made on behalf of the
2 insurer filing the form;

3 (B) the insurer is bound by the certification;

4 (C) the individual making the certification has
5 reviewed the form; and

6 (D) to the best knowledge, information, and
7 belief of the individual making the certification, the form
8 complies with this code and rules applicable to the form. (V.T.I.C.
9 Art. 3.42, Sec. (c) (part).)

10 Source Law

11 (c) [Each filing required under Subsection (a)
12 or (b) of this Article shall be made prior to any such
13 issuance, delivery or use of such form, contract or
14 policy.] On that filing, the insurer may immediately
15 issue, deliver and use such form, contract or policy,
16 provided such filing shall be accompanied by a
17 certification on behalf of the filing insurer, signed
18 by either an attorney licensed to practice law in this
19 state, an actuary familiar with the requirements of
20 this Code and the applicable rules and regulations
21 adopted pursuant thereto, or the chief executive
22 officer of such filing insurer or a person designated
23 by that officer. Such certification must affirm that
24 it is on behalf of the insurer, that the insurer is
25 bound thereby, that the person certifying has reviewed
26 the filing, and that, based upon that person's best
27 knowledge, information, and belief, such filed form,
28 contract, or policy complies in all respects with the
29 provisions of this Code and the adopted rules and
30 regulations that are applicable to such policy,
31 contract, certificate, application, rider,
32 endorsement, or other form being filed. . . .

33 Revisor's Note

34 (1) Section (c), V.T.I.C. Article 3.42, refers
35 to "rules and regulations." Throughout this chapter,
36 the revised law omits references to "regulations"
37 because under Section 311.005(5), Government Code
38 (Code Construction Act), a rule is defined to include a
39 regulation. That definition applies to the revised
40 law.

41 (2) Section (c), V.T.I.C. Article 3.42, refers
42 to a "policy, contract, certificate, application,
43 rider, endorsement, or other form being filed." The
44 revised law substitutes "form" for this reference to

1 provide for consistent use of terminology and because
2 the specific listing of types of forms is unnecessary.
3 The filing requirement applies to the form of a
4 document described by Section 1701.002. Those
5 documents include the specific types of documents
6 listed in the quoted language. The phrase "or other
7 form being filed" is unnecessary because V.T.I.C.
8 Article 3.42, revised as this chapter, does not
9 require the filing of the form of any document not
10 included in those documents.

11 Revised Law

12 Sec. 1701.053. FILING FEE. (a) The department shall
13 collect a fee in an amount determined by the commissioner for the
14 filing of the form of a document under this chapter.

15 (b) The fee may not exceed:

16 (1) \$100 for filing the form of a new or amended
17 document that is not exempt from review under Section 1701.005(b);
18 and

19 (2) \$50 for filing the form of a new or amended
20 document that is exempt from review under Section 1701.005(b).
21 (V.T.I.C. Art. 3.42, Secs. (e), (f) (part).)

22 Source Law

23 (e) The department shall charge and receive the
24 following fees in an amount to be determined by the
25 commissioner not to exceed the following:

26 (1) for a filing of policy forms,
27 amendments, endorsements, and riders filed for review
28 under this Article, unless exempted pursuant to
29 Subsection (h) of this Article, \$100; and

30 (2) for a filing of policy forms,
31 amendments, endorsements, and riders, exempted from
32 review pursuant to Subsection (h) of this Article,
33 \$50.

34 (f) The commissioner shall, within the limits
35 fixed by Subsection (e) of this Article, prescribe the
36 fees to be charged under Subsection (e) of this
37 Article. . . .

38 Revisor's Note

39 Section (f), V.T.I.C. Article 3.42, requires fees
40 collected under that article to be deposited in the
41 state treasury. The revised law omits that provision

1 as unnecessary. Section 404.094, Government Code,
2 requires all money, including the referenced fees,
3 collected or received by a state agency to be deposited
4 to the credit of the general revenue fund, which is
5 part of the state treasury. It is unnecessary to
6 repeat that requirement in this chapter. The omitted
7 law reads:

8 (f) . . . Fees collected under that
9 subsection shall be deposited in the State
10 Treasury.

11 Revised Law

12 Sec. 1701.054. APPROVAL OF FORM. (a) A form filed under
13 this chapter that is not affirmatively approved or disapproved in a
14 written order of the commissioner on or before the 60th day after
15 the date the form is filed is considered approved on the 61st day
16 after the date of filing unless the approval period is extended
17 under this section.

18 (b) An insurer may request in writing that the approval
19 period for a form be extended for an additional period not to exceed
20 45 days.

21 (c) An extension requested under this section is considered
22 granted on the date the department receives the request.

23 (d) Only one extension may be granted under this section.

24 (e) If an extension is granted under this section and the
25 commissioner does not affirmatively approve or disapprove the form
26 before the extended period expires, the form is considered approved
27 on the day after the date the extended period expires.

28 (f) If the commissioner approves a form that is filed
29 without a certification meeting the requirements of Section
30 1701.052(b) before the expiration of the approval period, including
31 any extension, the remaining portion of the period is waived.
32 (V.T.I.C. Art. 3.42, Secs. (c) (part), (d) (part).)

33 Source Law

34 (c) . . . At the expiration of 60 days after
35 receipt of such filed form, contract or policy by the
36 department, such form, contract or policy shall be

1 deemed approved by the department unless prior thereto
2 it has been affirmatively either approved or
3 disapproved by the written order of the commissioner,
4 or the insurer has requested in writing that the
5 approval period be extended for an additional period
6 not to exceed 45 days. The request for extension shall
7 be considered granted upon being received by the
8 department. Only one extension may be granted. On the
9 expiration of the extension, the form is considered
10 approved unless the commissioner has taken affirmative
11 action to either approve or disapprove the form before
12 the expiration of the extension. . . .

13 (d) [In lieu of and as an alternative to such
14 filing being accompanied by such certification as
15 required by Subsection (c) of this Article, any such
16 filing required hereby shall be made not less than 60
17 days in advance of any such issuance, delivery, or use
18 of such form, and] at the expiration of 60 days the
19 form so filed shall be deemed approved by the
20 commissioner unless prior thereto it has been
21 affirmatively approved or disapproved by the written
22 order of the commissioner. Approval of any such form
23 by the commissioner shall constitute a waiver of any
24 unexpired portion of the waiting period, or periods,
25 herein provided.

26 Revised Law

27 Sec. 1701.055. DISAPPROVAL OF FORM OR WITHDRAWAL OF
28 APPROVAL OR EXEMPTION. (a) Except as provided by Subsection (d),
29 the commissioner may disapprove or, after notice and hearing,
30 withdraw approval of a form if the form:

31 (1) violates this code, a rule of the commissioner, or
32 any other law; or

33 (2) contains a provision, title, or heading that is
34 unjust, encourages misrepresentation, or is deceptive.

35 (b) A form filed under this chapter that contains a
36 coordination of benefits provision may not be approved for use in
37 this state unless the form provides for the order of benefits
38 determination for insured dependent children. An order of benefits
39 determination provision may not be approved if the provision:

40 (1) violates this code, a rule of the commissioner, or
41 any other law; or

42 (2) contains a provision, title, or heading that is
43 unjust, encourages misrepresentation, or is deceptive.

44 (c) If necessary to accomplish the purpose of Subsection
45 (b), the commissioner may adopt a policy provision and order the
46 inclusion of that provision in a document subject to that

1 subsection.

2 (d) If a form has been on file with the department for at
3 least 180 days and has previously been affirmatively approved by
4 the commissioner, been considered approved under this chapter, or
5 been exempted from the approval requirements under this chapter,
6 the commissioner may withdraw the approval or exemption only if:

7 (1) the form violates this code or a rule adopted under
8 this code; or

9 (2) the commissioner finds proof of gross
10 misrepresentation or fraud to a policyholder.

11 (e) An order of the commissioner disapproving or
12 withdrawing approval for a form must state the grounds for the
13 disapproval or withdrawal of approval and describe in adequate
14 detail the changes that are necessary to obtain approval.

15 (V.T.I.C. Art. 3.42, Secs. (g) (part), (i), (j), (o).)

16 Source Law

17 (g) The order of the commissioner disapproving
18 any such form or withdrawing a previous approval must
19 state the grounds for such disapproval or withdrawal
20 and must describe in adequate detail the changes
21 necessary to obtain approval. . . .

22 (i) The commissioner may disapprove any such
23 form, or, after notice and hearing, may withdraw any
24 previous approval thereto if the form:

25 (1) violates or does not comply with this
26 Code or any valid rule relating thereto duly adopted by
27 the commissioner, or is otherwise contrary to law; or

28 (2) contains provisions or has any titles
29 or headings which are unjust, encourage
30 misrepresentation or are deceptive.

31 (j) If a form subject to Subsection (i) of this
32 Article has been on file with the department for at
33 least 180 days and has been previously affirmatively
34 approved by the commissioner, considered approved
35 under the operation of this Article, or exempted from
36 the approval requirements as provided by this Article,
37 the commissioner may withdraw the previous approval or
38 the exemption from the approval requirements only if
39 the form violates or does not comply with specific
40 requirements under this Code or a rule adopted under
41 this Code unless the commissioner finds proof of gross
42 misrepresentation or fraud to the policyholder.

43 (o) No policy, contract, or certificate filed
44 pursuant to this article that contains a coordination
45 of benefits provision may be approved for use in this
46 state unless it also provides the order of benefit
47 determination for insured dependent children. An
48 order of benefits determination provision may not be
49 approved unless it complies with the standards

1 specified in Subsection (i) of this article. The
2 commissioner is authorized to promulgate and may order
3 such provision as is necessary in the accomplishment
4 of the purpose of this subsection.

5 Revisor's Note

6 (1) Sections (i) and (j), V.T.I.C. Article 3.42,
7 include the language "violates or does not comply
8 with." The revised law omits the language "or does not
9 comply with" because "does not comply with" is
10 included in the meaning of "violates."

11 (2) Section (i), V.T.I.C. Article 3.42, refers
12 to a "valid rule." The revised law omits "valid" as
13 unnecessary because the word does not add to the clear
14 meaning of the law. A rule that is not valid has no
15 effect.

16 (3) Section (j), V.T.I.C. Article 3.42, refers
17 to a form that "violates . . . specific requirements
18 under this Code." The revised law omits "specific
19 requirements under" because the phrase does not add to
20 the clear meaning of the law. Violation of the
21 Insurance Code necessarily means violation of a
22 specific requirement.

23 Revised Law

24 Sec. 1701.056. USE OF DISAPPROVED FORM PROHIBITED. An
25 insurer who receives written notice that a form filed by the insurer
26 has been disapproved by the commissioner shall immediately stop
27 using the form. (V.T.I.C. Art. 3.42, Sec. (c) (part).)

28 Source Law

29 (c) . . . If such policy, contract or form is
30 affirmatively disapproved by the commissioner, the
31 insurer, upon receiving written notice thereof, shall
32 immediately cease issuing or using such policy,
33 contract or form. . . .

34 Revised Law

35 Sec. 1701.057. WITHDRAWAL OF INDIVIDUAL ACCIDENT AND HEALTH
36 INSURANCE POLICY FORM APPROVAL. (a) Except as provided by
37 Subsection (b), the commissioner may, after notice and hearing,
38 withdraw approval of an individual accident and health insurance

1 policy form if, after consideration of all relevant facts, the
2 commissioner determines that:

3 (1) the benefits provided under the form are
4 unreasonable in relation to the premium charged; or

5 (2) the reserve required by Section 862.102 is not
6 maintained by the insurer on the policies issued on the form.

7 (b) If an individual accident and health insurance policy
8 form has been on file with the department for at least 360 days and
9 has been affirmatively approved by the commissioner, been
10 considered approved under this chapter, or been exempted from the
11 approval requirements of this chapter, the commissioner may
12 withdraw the approval or exemption only if:

13 (1) the form violates this code or a rule adopted under
14 this code; or

15 (2) the commissioner finds proof of gross
16 misrepresentation or fraud to a policyholder.

17 (c) To enable the department to determine compliance with
18 Subsection (b), the commissioner:

19 (1) shall require an insurer to file the rates charged
20 by that insurer for individual accident and health insurance
21 policies; and

22 (2) may adopt and require an insurer to file in
23 conjunction with the annual statement required under Section
24 841.255, 982.101, or 982.103 a form for reporting the insurer's
25 experience on individual accident and health insurance policy forms
26 issued by the insurer.

27 (d) The commissioner shall, in accordance with Section
28 1201.007, adopt reasonable rules necessary to establish standards
29 under which the approval of an individual accident and health
30 insurance policy form may be withdrawn.

31 (e) This section does not grant the commissioner the
32 authority to determine, fix, prescribe, or promulgate rates to be
33 charged for an individual accident and health insurance policy.
34 (V.T.I.C. Art. 3.42, Secs. (k), (l), (m).)

1 Source Law

2 (k) The commissioner may, after notice and
3 hearing, withdraw any previous approval of an
4 individual accident and sickness insurance policy form
5 if, after consideration of all relevant facts, the
6 commissioner finds that the benefits provided under
7 such policy form are unreasonable in relation to the
8 premium charged, or the reserve required by Article
9 6.01 of this code is not maintained by the insurer on
10 the policies issued upon such policy form. The
11 commissioner shall from time to time as conditions
12 warrant, and after notice and hearing, promulgate such
13 reasonable rules and regulations and amendments
14 thereto as are necessary to establish the standard or
15 standards by which any previous approval of a policy
16 form may be withdrawn. Any such rule or regulation
17 shall be promulgated in accordance with Section 10,
18 Chapter 397, Acts of the 54th Legislature, 1955
19 (Article 3.70-10, Vernon's Texas Insurance Code).
20 Nothing in this section shall be construed as granting
21 the commissioner any power or authority to determine,
22 fix, prescribe, or promulgate the rates to be charged
23 for any individual accident and sickness insurance
24 policy or policies.

25 (l) If a form subject to Subsection (k) of this
26 Article has been on file with the department for at
27 least 360 days and has been previously affirmatively
28 approved by the commissioner, considered approved
29 under the operation of this Article, or exempted from
30 the approval requirements as provided by this Article,
31 the commissioner may withdraw the previous approval or
32 the exemption from the approval requirements only if
33 the form violates or does not comply with specific
34 requirements under this Code or a rule adopted under
35 this Code unless the commissioner finds proof of gross
36 misrepresentation or fraud to the policyholder.

37 (m) The commissioner shall require the filing of
38 all rates to be charged for individual accident and
39 sickness policies and may adopt necessary forms to be
40 filed by insurers in conjunction with the annual
41 statement required under Articles 3.07 and 3.20-1 of
42 this code for reporting the experience on all
43 individual accident and sickness insurance policy
44 forms issued by the insurer so as to determine
45 compliance with Subsection (l) of this Article.

46 Revisor's Note

47 (1) Sections (k) and (m), V.T.I.C. Article 3.42,
48 refer to "individual accident and sickness insurance."
49 For consistency with modern usage, the revised law
50 substitutes "health" for "sickness."

51 (2) Section (k), V.T.I.C. Article 3.42, gives
52 the commissioner the authority to "from time to time as
53 conditions warrant, and after notice and hearing,
54 promulgate such reasonable rules and regulations and
55 amendments thereto." The revised law omits the

1 language "from time to time as conditions warrant"
2 because the authority to adopt rules includes the
3 authority to adopt them at appropriate times under
4 appropriate conditions. The revised law omits the
5 reference to "notice and hearing" because the section
6 also requires the rules to be adopted in compliance
7 with V.T.I.C. Article 3.70-10, revised as Section
8 1201.007, which also contains a notice and hearing
9 requirement. The revised law omits the reference to
10 "amendments thereto" because, as explained in
11 Revisor's Note (1) to Section 1701.060, the authority
12 to adopt rules includes the authority to amend those
13 rules.

14 (3) Section (1), V.T.I.C. Article 3.42,
15 includes the language "violates or does not comply
16 with specific requirements under this Code." The
17 revised law omits the language "or does not comply
18 with" for the reason stated in Revisor's Note (1) to
19 Section 1701.055. The revised law omits the language
20 "specific requirements under" for the reason stated in
21 Revisor's Note (3) to Section 1701.055.

22 Revised Law

23 Sec. 1701.058. RECONSIDERATION OF FORM. (a) Not later
24 than the 45th day after the date of an order of the commissioner
25 disapproving or withdrawing approval of a form under Section
26 1701.055, an insurer may correct the deficiencies described by the
27 order and file the corrected form with the department for
28 reconsideration by the commissioner.

29 (b) If the commissioner does not approve or disapprove a
30 form filed for reconsideration under this section on or before the
31 45th day after the date the form is filed, the form is considered
32 approved on the 46th day after the date the form is filed.
33 (V.T.I.C. Art. 3.42, Sec. (g) (part).)

1 Source Law

2 (g) . . . The insurer is entitled to 45 days
3 after the date of the order to make the changes
4 required to correct the deficiencies noted in the
5 order. The commissioner has 45 days to approve or
6 disapprove the form filed for reconsideration or the
7 form is considered approved for purposes of this
8 Article.

9 Revised Law

10 Sec. 1701.059. REPLACEMENT OR AMENDMENT OF DOCUMENT. The
11 commissioner may order an insurer to replace a document described
12 by Section 1701.002 with a corrected document or to amend and
13 correct the document by endorsement or rider if:

14 (1) the commissioner disapproves or withdraws
15 approval of the form of the document under Section 1701.055(a); or

16 (2) the document is used before the form was approved
17 under this chapter and corrections must be made to the document to
18 bring the document into compliance with this code and rules of the
19 commissioner before the commissioner will approve the form of the
20 document. (V.T.I.C. Art. 3.42, Sec. (c) (part).)

21 Source Law

22 (c) . . . If any such filed contract, policy or
23 form is used, issued, or delivered prior to either
24 affirmative or statutory deemer approval, and if
25 corrections are required to be made before the
26 commissioner will approve the contract, policy or form
27 to bring the contract, policy or form into complete
28 compliance with the provisions of this Code and the
29 applicable rules of the commissioner, the commissioner
30 may order the insurer either to reissue a corrected
31 contract, policy or form to replace the one previously
32 issued, delivered, or used, or to amend and correct it
33 by endorsement or rider. If a contract, policy or form
34 is disapproved or approval is withdrawn under the
35 provisions of Subsection (i) of this Article, the
36 commissioner may order a similar replacement or
37 amendment to correct the original contract, policy or
38 form. . . .

39 Revised Law

40 Sec. 1701.060. GENERAL RULEMAKING AUTHORITY. (a) The
41 commissioner may, within the standards and purposes of this
42 chapter, adopt reasonable rules necessary to implement this
43 chapter, including, after notice and hearing, rules that establish
44 procedures and criteria under which:

45 (1) each type of form submitted to the department

1 under this chapter will be reviewed and approved by the
2 commissioner or exempted under Section 1701.005(b); and

3 (2) particular types of forms designated by the
4 commissioner may be given a summary review and approval if
5 considered appropriate by the commissioner to expedite review and
6 approval of those forms.

7 (b) A rule adopted under this chapter may not be repealed or
8 amended before the first anniversary of the date the rule was
9 adopted unless the commissioner determines after notice and in a
10 public hearing that there is a compelling public need for the rule
11 to be repealed or amended. (V.T.I.C. Art. 3.42, Secs. (h) (part),
12 (p) (part).)

13 Source Law

14 (h) . . . Additionally, the commissioner may,
15 after notice and hearing, adopt reasonable rules and
16 amendments to rules that are necessary for the
17 commissioner to establish guidelines, procedures,
18 methods, standards, and criteria by which the various
19 and different types of forms and documents submitted
20 to the department are to be reviewed and approved by
21 the commissioner as in compliance with this article or
22 exempted under this subsection, and to provide those
23 guidelines, procedures, methods, standards, and
24 criteria by which a summary review and approval may be
25 given to those particular types of forms and documents
26 designated by the commissioner that, in the
27 commissioner's opinion, will expedite the review and
28 approval process of those forms and documents.

29 (p) The commissioner is hereby authorized to
30 adopt such reasonable rules and regulations as are
31 necessary to implement and accomplish the specific
32 provisions of this Article and are within the
33 standards and purposes of this Article. . . . A rule
34 adopted under this Article may not be repealed or
35 amended until the first anniversary of the adoption of
36 the rule unless the commissioner finds in a public
37 hearing after notice that there is a compelling public
38 need for the amendment or repeal of the rule or part of
39 the rule.

40 Revisor's Note

41 (1) Section (h), V.T.I.C. Article 3.42,
42 authorizes the commissioner to amend rules. The
43 authority to amend rules is implied in the authority to
44 adopt rules. Chapter 2001, Government Code
45 (Administrative Procedure Act), provides uniform
46 procedures for state agencies and defines "rule" to

1 include the amendment of a prior rule. The revised law
2 omits as unnecessary the language authorizing the
3 commissioner to amend rules.

4 (2) Section (h), V.T.I.C. Article 3.42, refers
5 to "guidelines, procedures, methods, standards, and
6 criteria." The revised law omits the references to
7 "guidelines" and "standards" because the meaning of
8 "guidelines" and "standards" is included in the
9 meaning of "criteria" and omits the references to
10 "methods" because the meaning of "methods" is included
11 in the meaning of "procedures."

12 (3) Section (p), V.T.I.C. Article 3.42,
13 requires that the commissioner adopt rules in
14 compliance with Chapter 2001, Government Code
15 (Administrative Procedure Act). The revised law omits
16 the reference to that chapter because that chapter
17 requires a state agency, including a state officer, to
18 adopt rules in accordance with its provisions, and it
19 is not necessary to restate that requirement in this
20 chapter. The omitted law reads:

21 (p) . . . The commissioner shall
22 adopt rules under this Article in
23 compliance with Chapter 2001, Government
24 Code (Administrative Procedure Act). . . .

25 (4) Section (p), V.T.I.C. Article 3.42,
26 authorizes the commissioner to adopt rules to
27 implement the "specific provisions of this Article,"
28 revised as this chapter. The revised law omits
29 "specific provisions of" because the phrase does not
30 add to the clear meaning of the law. The chapter
31 consists of its specific provisions and implementation
32 of the chapter requires implementation of its
33 provisions.

34 [Sections 1701.061-1701.100 reserved for expansion]

1 SUBCHAPTER C. SANCTIONS; APPLICABILITY OF OTHER LAWS

2 Revised Law

3 Sec. 1701.101. RESTITUTION. (a) The commissioner may
4 order an insurer to make complete restitution to each insured of
5 this state who is financially damaged by the insurer's use of a form
6 filed and used but not approved under this chapter if, after notice
7 and opportunity for hearing, the commissioner determines:

8 (1) the form does not comply with this code and the
9 rules of the commissioner;

10 (2) use of the form resulted in financial damage to an
11 insured of this state; and

12 (3) the insurer intentionally used the form with the
13 knowledge that it did not comply with this code and the rules of the
14 commissioner.

15 (b) The commissioner may determine the form and amount of
16 restitution ordered under this section and the period in which the
17 restitution must be made. (V.T.I.C. Art. 3.42, Sec. (c) (part).)

18 Source Law

19 (c) . . . In the event it is determined after
20 notice and opportunity for hearing that Texas insureds
21 have been financially damaged by the use of a contract,
22 policy or form filed and used under this subsection but
23 that has not been approved as provided by this
24 subsection and that does not comply with this Code and
25 legally adopted applicable rules of the commissioner,
26 and the commissioner determines that the insurer
27 intentionally used and issued that contract, policy or
28 form with the knowledge that it did not comply with
29 this Code or those applicable rules, the commissioner
30 may order the insurer to make complete restitution to
31 those financially damaged insureds in such form and
32 amount and within such time period as determined by the
33 commissioner. . . .

34 Revisor's Note

35 Section (c), V.T.I.C. Article 3.42, refers to
36 "legally adopted applicable rules of the
37 commissioner." The revised law omits "legally adopted
38 applicable" as unnecessary because the words do not
39 add to the clear meaning of the law. A rule that is not
40 legally adopted and applicable has no effect.

1 Revised Law

2 Sec. 1701.102. LIMIT ON SANCTIONS. Except as provided by
3 Section 1701.101, the commissioner may not impose penalties or
4 other sanctions on an insurer for the issuance of a document the
5 form of which is filed under Section 1701.052. (V.T.I.C. Art. 3.42,
6 Sec. (c) (part).)

7 Source Law

8 (c) . . . the commissioner may not impose other
9 sanctions or penalties on an insurer for the issuance
10 of a form, policy, or contract filed under this
11 subsection except as specifically provided by this
12 subsection.

13 Revised Law

14 Sec. 1701.103. APPLICABILITY OF OTHER LAWS. Except as
15 provided by Section 1701.102, this chapter may not be construed to
16 limit the applicability of any other statute. (V.T.I.C. Art. 3.42,
17 Sec. (c) (part).)

18 Source Law

19 (c) . . . This section shall not be construed
20 to be in derogation or to in any way limit the
21 applicability of any otherwise applicable statute,
22 but

23 Revisor's Note

24 Section (c), V.T.I.C. Article 3.42, states that
25 the section "shall not be construed to be in derogation
26 or to in any way limit the applicability" of an
27 applicable statute. The revised law omits "to be in
28 derogation" because the meaning of that phrase is
29 included in the meaning of "limit the applicability."

30 [Sections 1701.104-1701.150 reserved for expansion]

31 SUBCHAPTER D. CERTAIN POLICY APPLICATION FORMS

32 Revised Law

33 Sec. 1701.151. POLICY APPLICATION FORM FOR INDIVIDUAL
34 ACCIDENT AND HEALTH POLICY. A policy application form that is
35 required to be or that is attached to an individual accident and
36 health policy shall comply with the rules of the commissioner
37 adopted under Chapter 1201. (V.T.I.C. Art. 3.42, Sec. (b) (part).)

1 CHAPTER 2553. FOREIGN OR ALIEN CORPORATIONS
2 [Chapters 2554-2600 reserved for expansion]
3 SUBTITLE C. FINANCIAL SOLVENCY
4 CHAPTER 2601. SUPERVISION, LIQUIDATION, REHABILITATION,
5 REORGANIZATION, OR CONSERVATION OF TITLE
6 INSURANCE COMPANIES AND AGENTS
7 CHAPTER 2602. TEXAS TITLE INSURANCE GUARANTY ASSOCIATION
8 [Chapters 2603-2650 reserved for expansion]
9 SUBTITLE D. TITLE INSURANCE PROFESSIONALS
10 CHAPTER 2651. TITLE INSURANCE AGENTS AND DIRECT OPERATIONS
11 CHAPTER 2652. ESCROW OFFICERS
12 [Chapters 2653-2700 reserved for expansion]
13 SUBTITLE E. THE BUSINESS OF TITLE INSURANCE
14 CHAPTER 2701. GENERAL PROVISIONS
15 CHAPTER 2702. CLOSING AND SETTLEMENT
16 CHAPTER 2703. POLICY FORMS AND PREMIUM RATES
17 CHAPTER 2704. ISSUANCE OF POLICY OR CONTRACT; DETERMINATION OF
18 INSURABILITY
19 TITLE 11. TITLE INSURANCE
20 SUBTITLE A. GENERAL PROVISIONS
21 CHAPTER 2501. GENERAL PROVISIONS
22 Sec. 2501.001. SHORT TITLE. 1407
23 Sec. 2501.002. PURPOSE; LEGISLATIVE INTENT 1408
24 Sec. 2501.003. DEFINITIONS 1408
25 Sec. 2501.004. ABSTRACT PLANT; JOINT ABSTRACT PLANT
26 OPERATION 1413
27 Sec. 2501.005. BUSINESS OF TITLE INSURANCE 1414
28 Sec. 2501.006. CLOSING THE TRANSACTION. 1415
29 Sec. 2501.007. REFERENCES TO TITLE 1416
30 CHAPTER 2501. GENERAL PROVISIONS
31 Revised Law
32 Sec. 2501.001. SHORT TITLE. This title may be cited as the
33 Texas Title Insurance Act. (V.T.I.C. Art. 9.01, Sec. A.)

1 unless the context indicates otherwise.

2 (4) "Escrow officer" means an attorney, a bona fide
3 employee of an attorney licensed as an escrow officer, a bona fide
4 employee of a direct operation, or a bona fide employee of a title
5 insurance agent whose responsibilities include:

6 (A) countersigning title insurance forms;

7 (B) supervising the preparation and delivery of
8 title insurance forms;

9 (C) signing escrow checks; or

10 (D) closing the transaction, as described by
11 Section 2501.006.

12 (5) "Foreign title insurance company" means a title
13 insurance company organized under the laws of a jurisdiction other
14 than this state.

15 (6) "Joint abstract plant operation" means a joint
16 abstract plant operation as defined by the department under Section
17 2501.004.

18 (7) "Person" includes an individual, corporation,
19 association, partnership, or trust.

20 (8) "Premium" means the premium rates promulgated by
21 the commissioner under Subchapters D and E, Chapter 2703, and
22 includes a charge for:

23 (A) title examination and closing the
24 transaction, regardless of whether the examination or closing is
25 performed by an attorney; and

26 (B) issuing the policy.

27 (9) "Residential real property" means real property
28 that is improved and is designed principally for occupancy by one to
29 four families. The term includes an individual unit of a
30 condominium or cooperative.

31 (10) "Thing of value" includes any payment, advance,
32 funds, loan, service, or other consideration.

33 (11) "Title examination" means the search and
34 examination of a title to determine the conditions of the title to

1 be insured and to evaluate the risk to be undertaken in the issuance
2 of a title insurance policy or other title insurance form.

3 (12) "Title insurance" means:

4 (A) insurance that insures, guarantees, or
5 indemnifies an owner of real property, or another interested in the
6 real property, against loss or damage resulting from:

7 (i) a lien or encumbrance on or defect in
8 the title to the real property; or

9 (ii) the invalidity or impairment of a lien
10 on the real property; or

11 (B) any business that is substantially
12 equivalent to the insurance described by Paragraph (A) and is
13 conducted in a manner designed to evade the provisions of this
14 title.

15 (13) "Title insurance agent" means a person owning or
16 leasing and controlling an abstract plant or as a participant in a
17 bona fide joint abstract plant operation and authorized in writing
18 by a title insurance company to solicit insurance and collect
19 premiums and to issue or countersign policies on the company's
20 behalf.

21 (14) "Title insurance company" means:

22 (A) a domestic company organized under this title
23 to engage in the business of title insurance, as described by
24 Section 2501.005;

25 (B) a foreign title insurance company that:

26 (i) meets the requirements of this title;
27 and

28 (ii) holds a certificate of authority to
29 engage in business in this state; or

30 (C) any other domestic or foreign company that:

31 (i) meets the requirements of this title;
32 and

33 (ii) holds a certificate of authority to
34 insure a title to real property in this state. (V.T.I.C. Art. 9.02,

1 Secs. (a), (c), (f) (part), (g), (h), (i) (part), (j), (k), (l),
2 (m), (o), (p), (q); New.)

3 Source Law

4 Art. 9.02. (a) "Title Insurance" means
5 insuring, guaranteeing or indemnifying owners of real
6 property or others interested therein against loss or
7 damage suffered by reason of liens, encumbrances upon,
8 or defects in the title to said property, and the
9 invalidity or impairment of liens thereon, or doing
10 any business in substance equivalent to any of the
11 foregoing in a manner designed to evade the provisions
12 of this Act.

13 (c) "Title Insurance Company" means any
14 domestic company organized under the provisions of
15 this Act for the purpose of conducting the business of
16 title insurance, any title insurance company organized
17 under the laws of another state or foreign government
18 meeting the requirements of this Act and holding a
19 certificate of authority to transact business in Texas
20 and any domestic or foreign company having a
21 certificate of authority to insure titles to real
22 estate within this state and which meet the
23 requirements of this Act.

24 (f) "Title Insurance Agent" means a person,
25 firm, association, or corporation owning or leasing
26 and controlling an abstract plant [as defined by the
27 Board,] or as a participant in a bona fide joint
28 abstract plant operation [as defined by the Board,]
29 and authorized in writing by a title insurance company
30 to solicit insurance and collect premiums and to issue
31 or countersign policies in its behalf.

32 (g) "Escrow Officer" means an attorney, or bona
33 fide employee of either an attorney licensed as an
34 escrow officer, bona fide employee of a direct
35 operation, or bona fide employee of a title insurance
36 agent whose duties include any or all of the following:
37 (1) countersigning title insurance forms; or (2)
38 supervising the preparation and supervising the
39 delivery of title insurance forms; or (3) signing
40 escrow checks; or (4) closing the transaction.

41 (h) "Foreign Title Insurance Company" means a
42 title insurance company organized under the laws of
43 any jurisdiction other than the State of Texas.

44 (i) "Abstract plant" as used herein shall mean a
45 geographical abstract plant such as is defined by the
46 commissioner, and

47 (j) "Residential real property" means any real
48 property which has improvements thereon and is
49 designed principally for the occupancy of from one to
50 four families (including individual units of
51 condominiums and cooperatives).

52 (k) "Thing of value" includes any payment,
53 advance, funds, loan, service, or other consideration.

54 (l) "Person" includes individuals,
55 corporations, associations, partnerships and trusts.

56 (m) "Title Examination" means the search and
57 examination of a title to determine the conditions of
58 the title to be insured and to evaluate the risk to be
59 undertaken in the issuance of a title insurance policy
60 or other title insurance form.

61 (o) "Premium" means the premium rates

1 promulgated by the Board pursuant to Article 9.07 of
2 this Code and includes the charges for title
3 examination and for closing the transaction, whether
4 or not performed by an attorney, and for issuance of a
5 policy.

6 (p) "Attorney" means a person licensed to
7 practice law and a member of the State Bar of Texas and
8 includes a Texas professional corporation organized
9 for the purpose of rendering professional legal
10 services.

11 (q) "Direct Operation" means the operations of a
12 title insurance company under the authority of a
13 license issued under Article 9.36A of this Code.
14 Whenever the term "title insurance agent" is used in
15 this Chapter, it shall be construed to include "direct
16 operation" unless the context indicates to the
17 contrary.

18 Revisor's Note

19 (1) Section (d), V.T.I.C. Article 9.02, defines
20 "commissioner." The revised law omits the definition
21 as unnecessary. The term "commissioner" is defined
22 for purposes of this code by Section 31.001 of this
23 code. That definition applies to this chapter. The
24 omitted law reads:

25 (d) "Commissioner" means the
26 Commissioner of Insurance of the State of
27 Texas.

28 (2) Section (e), V.T.I.C. Article 9.02, defines
29 "board" as the State Board of Insurance. The revised
30 law omits the definition as unnecessary. Chapter 685,
31 Acts of the 73rd Legislature, Regular Session, 1993,
32 abolished the board and transferred its functions to
33 the commissioner of insurance and the Texas Department
34 of Insurance. Throughout this title, references to
35 the board have been changed appropriately. The
36 omitted law reads:

37 (e) "Board" means the State Board of
38 Insurance of the State of Texas.

39 (3) Section (f), V.T.I.C. Article 9.02, refers
40 to a "person, firm, association, or corporation."
41 Section (l), V.T.I.C. Article 9.02, revised in this
42 section, defines "person" for purposes of this title
43 to include "individuals, corporations, associations,
44 partnerships and trusts." Because the substance of

1 the definition of "person" includes a "firm,"
2 "association," and "corporation," the revised law
3 omits the references to those terms as unnecessary.

4 (4) Section (i), V.T.I.C. Article 9.02, refers
5 to a "geographical" abstract plant. The revised law
6 omits "geographical" as unnecessary. In defining
7 abstract plant under that subsection, revised as
8 Section 2501.004, the department is required to
9 provide for a geographically arranged plant.

10 (5) The definition of "joint abstract plant
11 operation" is added to the revised law for the
12 convenience of the reader and for consistency with
13 other provisions in this chapter.

14 Revised Law

15 Sec. 2501.004. ABSTRACT PLANT; JOINT ABSTRACT PLANT
16 OPERATION. (a) For purposes of this title, the department shall
17 define "abstract plant" and "joint abstract plant operation."

18 (b) To provide for the safety and protection of
19 policyholders, the department shall require that an abstract plant
20 be:

- 21 (1) geographically arranged;
- 22 (2) kept current; and
- 23 (3) adequate for use in insuring titles, as determined
24 by the department. (V.T.I.C. Art. 9.02, Secs. (f) (part), (i)
25 (part).)

26 Source Law

27 [(f) "Title Insurance Agent" means a person,
28 firm, association, or corporation owning or leasing
29 and controlling an abstract plant] as defined by the
30 Board, or [as a participant in a bona fide joint
31 abstract plant operation] as defined by the Board,
32 and

33 [(i) "Abstract plant" as used herein shall mean
34 a geographical abstract plant such as is defined by the
35 commissioner, and] the commissioner, in defining an
36 abstract plant, shall require a geographically
37 arranged plant, currently kept to date, that is found
38 by the commissioner to be adequate for use in insuring
39 titles, so as to provide for the safety and protection
40 of the policyholders.

1 Revised Law

2 Sec. 2501.005. BUSINESS OF TITLE INSURANCE. (a) For
3 purposes of this title, a person engages in the business of title
4 insurance if the person:

5 (1) as insurer, guarantor, or surety, makes or
6 proposes to make a contract or policy of title insurance or its
7 equivalent;

8 (2) transacts or proposes to transact any phase of
9 title insurance, including:

10 (A) soliciting;

11 (B) title examination other than an examination
12 conducted by an attorney;

13 (C) closing the transaction other than a closing
14 conducted by an attorney;

15 (D) executing a contract of title insurance; and

16 (E) insuring and transacting matters arising out
17 of the contract after the contract is executed, including
18 reinsurance; or

19 (3) makes a guaranty or warranty of a title search or a
20 title examination, or any component of a title search or title
21 examination, if the person is not the person who performs the search
22 or examination.

23 (b) A person engages in the business of title insurance if
24 the person engages in or proposes to engage in any business that is
25 substantially equivalent to the business of title insurance as
26 described by this section, regardless of whether that conduct is
27 performed in a manner designed to evade the provisions of this
28 title. (V.T.I.C. Art. 9.02, Sec. (b).)

29 Source Law

30 (b) The "business of title insurance" shall be
31 deemed to be (1) the making as insurer, guarantor or
32 surety, or proposing to make as insurer, guarantor or
33 surety, of any contract or policy of title insurance or
34 any equivalent thereof; (2) the transacting or
35 proposing to transact, any phase of title insurance,
36 including solicitation, title examination, except
37 when conducted by an attorney, closing the
38 transaction, except when conducted by an attorney,

1 execution of a contract of title insurance, insuring
2 and transacting matters subsequent to the execution of
3 the contract and arising out of it, including
4 reinsurance; (3) the making of a guaranty or warranty
5 of a title search, a title examination, or any
6 component thereof by a person other than the one
7 performing the search or examination; or (4) the
8 doing, or proposing to do, any business in substance
9 equivalent to any of the foregoing whether or not
10 designed to evade the provisions of this Act.

11 Revised Law

12 Sec. 2501.006. CLOSING THE TRANSACTION. (a) For purposes
13 of this title, "closing the transaction" describes the
14 investigation that is made:

15 (1) on behalf of a title insurance company, title
16 insurance agent, or direct operation before the title insurance
17 policy is issued; and

18 (2) to determine proper execution, acknowledgment,
19 and delivery of all conveyances, mortgage papers, and other title
20 instruments necessary to consummate a transaction.

21 (b) Closing the transaction includes a determination that:

22 (1) all delinquent taxes have been paid;

23 (2) in the case of an owner title insurance policy, all
24 current taxes, based on the latest available information, have been
25 properly prorated between the purchaser and seller;

26 (3) the consideration has been passed;

27 (4) all proceeds have been properly disbursed;

28 (5) a final search of the title has been made; and

29 (6) all necessary papers have been filed for record.

30 (V.T.I.C. Art. 9.02, Sec. (n).)

31 Source Law

32 (n) "Closing the Transaction" means the
33 investigation made on behalf of a title insurance
34 company, title insurance agent, or direct operation
35 before the actual issuance of the title policy to
36 determine proper execution, acknowledgment, and
37 delivery of all conveyances, mortgage papers, and
38 other title instruments which may be necessary to the
39 consummation of the transaction and includes the
40 determination that all delinquent taxes are paid, all
41 current taxes, based on the latest available
42 information, have been properly prorated between the
43 purchaser and seller in the case of an owner policy,
44 the consideration has been passed, all proceeds have
45 been properly disbursed, a final search of the title
46 has been made, and all necessary papers have been filed

1 for record.

2 Revised Law

3 Sec. 2501.007. REFERENCES TO TITLE. In this title, a
4 reference to this title includes a reference to:

- 5 (1) Chapter 223;
- 6 (2) Chapter 271;
- 7 (3) Section 171.0527, Tax Code; and
- 8 (4) Subchapter U, Chapter 171, Tax Code. (New.)

9 Revisor's Note

10 This title is derived from a majority of the
 11 articles previously contained in Chapter 9, Insurance
 12 Code. References in those articles to "this chapter"
 13 or "Chapter 9" are revised in this title as references
 14 to "this title." However, the logical organization of
 15 this code required various portions of Chapter 9 to be
 16 revised in other titles of this code or in other codes.
 17 As a result, this new section is necessary to ensure
 18 the continued applicability of provisions revised in
 19 this title to the portions of Chapter 9 revised
 20 elsewhere.

21 CHAPTER 2502. PROHIBITED CONDUCT

22 SUBCHAPTER A. PROHIBITED CONDUCT IN GENERAL

23 Sec. 2502.001. ENGAGING IN CERTAIN INSURANCE BUSINESS

24 PROHIBITED 1417

25 Sec. 2502.002. COVERAGE FOR UNMARKETABILITY OF TITLE

26 PROHIBITED 1418

27 Sec. 2502.003. INSURING AROUND DEFINED; PROHIBITIONS AND

28 EXCEPTIONS 1418

29 Sec. 2502.004. GUARANTEE OF MORTGAGE PAYMENT PROHIBITED . . . 1419

30 Sec. 2502.005. CIVIL PENALTY 1420

31 [Sections 2502.006-2502.050 reserved for expansion]

32 SUBCHAPTER B. REBATES AND DISCOUNTS

33 Sec. 2502.051. REBATES AND DISCOUNTS PROHIBITED 1421

34 Sec. 2502.052. CERTAIN DIVISIONS OF REAL PROPERTY CHARGES

1 PROHIBITED 1422

2 Sec. 2502.053. CERTAIN COMPENSATORY PAYMENTS NOT

3 PROHIBITED 1422

4 Sec. 2502.054. CERTAIN DIVISIONS OF PREMIUMS NOT

5 PROHIBITED 1423

6 Sec. 2502.055. CERTAIN PROMOTIONAL AND EDUCATIONAL

7 ACTIVITIES NOT PROHIBITED 1423

8 Sec. 2502.056. MONETARY FORFEITURE 1425

9 CHAPTER 2502. PROHIBITED CONDUCT

10 SUBCHAPTER A. PROHIBITED CONDUCT IN GENERAL

11 Revised Law

12 Sec. 2502.001. ENGAGING IN CERTAIN INSURANCE BUSINESS

13 PROHIBITED. (a) A domestic or foreign corporation operating

14 under this title may not engage in the business of any kind of

15 insurance other than title insurance.

16 (b) A company may not engage in the business of title

17 insurance if the company engages in the business of another kind of

18 insurance. (V.T.I.C. Art. 9.09.)

19 Source Law

20 Art. 9.09. Corporations, domestic or foreign,

21 operating under this Chapter shall not transact,

22 underwrite or issue any kind of insurance other than

23 title insurance on real property; nor shall the

24 business of title insurance be transacted,

25 underwritten, or issued by any company transacting any

26 other kinds of insurance.

27 Revisor's Note

28 (1) V.T.I.C. Article 9.09 refers to

29 corporations that "transact, underwrite or issue"

30 insurance and to insurance being "transacted,

31 underwritten, or issued" by companies. The revised

32 law substitutes "engage in the business

33 of . . . insurance" for the reference because it is a

34 general description that covers the subject of the

35 reference.

36 (2) V.T.I.C. Article 9.09 refers to title

37 insurance "on real property." The revised law omits

1 "on real property" as unnecessary because title
2 insurance provides insurance only for real property.

3 Revised Law

4 Sec. 2502.002. COVERAGE FOR UNMARKETABILITY OF TITLE
5 PROHIBITED. (a) An insurance company may not insure against loss
6 or damage by reason of unmarketability of title.

7 (b) The commissioner may not adopt a rule or form providing
8 for coverage prohibited by this section. (V.T.I.C. Art. 9.09A.)

9 Source Law

10 Art. 9.09A. An insurance company may not insure
11 against loss or damage by reason of unmarketability of
12 title. The commissioner may not promulgate rules or
13 forms providing for that coverage.

14 Revised Law

15 Sec. 2502.003. INSURING AROUND DEFINED; PROHIBITIONS AND
16 EXCEPTIONS. (a) Except as provided by Subsection (c), a title
17 insurance company may not wilfully issue a binder for title
18 insurance or a title insurance policy showing no outstanding
19 enforceable recorded liens on real property against which the
20 company knows an outstanding enforceable recorded lien exists.

21 (b) A title insurance company knows that an outstanding
22 enforceable recorded lien exists against real property if, based on
23 an examination of the title under which the binder for title
24 insurance or title insurance policy is issued, the company
25 determines that the lien is valid and enforceable.

26 (c) The commissioner by rule may approve circumstances
27 under which a title insurance company may issue a binder for title
28 insurance or a title insurance policy otherwise prohibited by
29 Subsection (a).

30 (d) Except as otherwise provided by this section, a title
31 insurance company may determine the insurability of title to real
32 property and any other matter that the company considers to be
33 insurable under a binder for title insurance or a title insurance
34 policy issued in connection with the property. (V.T.I.C. Art. 9.08
35 (part).)

1 Source Law

2 Art. 9.08. . . .

3 "Insuring around" is defined as the willful
4 issuance of a title binder or title insurance policy
5 showing no outstanding enforceable recorded liens
6 while the title insurance company knows that in fact a
7 lien or liens are of record against the real property,
8 and shall be prohibited, except under circumstances as
9 the commissioner under his or her rule-making powers
10 shall approve. A title insurance company knows that an
11 outstanding enforceable recorded matter exists if it
12 determines that the matter is valid and enforceable
13 based on the examination of the title pursuant to which
14 the title binder or title insurance policy is issued.
15 In its discretion, the title insurance company may
16 determine the insurability of title and those matters
17 which it considers to be insurable under the title
18 binder or title insurance policy; provided, however,
19 that insuring around enforceable recorded liens shall
20 be prohibited except as allowed by regulation.

21 . . .

22 Revisor's Note

23 V.T.I.C. Article 9.08 prohibits a title insurance
24 company from issuing a policy for property that shows
25 "no outstanding enforceable recorded liens" if the
26 company knows that "a lien or liens are of record"
27 against the property. The revised law adds the terms
28 "outstanding" and "enforceable" to the latter quoted
29 language for consistency with the previous quoted
30 language.

31 Revised Law

32 Sec. 2502.004. GUARANTEE OF MORTGAGE PAYMENT PROHIBITED.

33 (a) A title insurance company may not guarantee the payment of a
34 mortgage on real property.

35 (b) A title insurance company that violates this section
36 forfeits its authority to engage in business in this state and shall
37 immediately surrender its certificate of authority. (V.T.I.C. Art.
38 9.08 (part).)

39 Source Law

40 Art. 9.08. Title insurance companies, domestic
41 or foreign, operating under this chapter shall not
42 have the right to guarantee the payment of mortgages
43 which cover real estate, and if any such corporation
44 shall do so it shall forthwith forfeit and surrender
45 its permit to do business. . . .

1 Revisor's Note

2 (1) V.T.I.C. Article 9.08 refers to "[t]itle
3 insurance companies, domestic or foreign, operating
4 under this chapter." Throughout this chapter, the
5 revised law substitutes "title insurance company" for
6 the reference and for other similar references because
7 under V.T.I.C. Article 9.02, revised as Section
8 2501.003 of this code, a "title insurance company" is
9 defined to include both domestic and foreign
10 companies, and all title insurance companies operate
11 under Chapter 9, Insurance Code, revised as this
12 title.

13 (2) V.T.I.C. Article 9.08 refers to a "permit to
14 do business." The revised law substitutes
15 "certificate of authority" for "permit" because under
16 V.T.I.C. Article 9.15, revised in relevant part as
17 Section 2551.102 of this code, a title insurance
18 company is issued a certificate of authority to engage
19 in business in this state.

20 Revised Law

21 Sec. 2502.005. CIVIL PENALTY. (a) A person is liable to
22 the state for a civil penalty of not more than \$5,000 if the person:

23 (1) wilfully violates Section 2502.003 or 2502.004; or

24 (2) violates an order of the commissioner refusing to
25 approve an application to issue a binder for title insurance or a
26 title insurance policy prohibited by Section 2502.003(a).

27 (b) The department may bring an action in a Travis County
28 district court to recover the penalty provided by this section.

29 (V.T.I.C. Art. 9.08 (part).)

30 Source Law

31 Art. 9.08. . . .

32 Any person who willfully violates the provisions
33 of this Article 9.08, or who disobeys an order of the
34 commissioner refusing to approve an application to
35 insure around, shall, upon proof thereof to the
36 satisfaction of the District Court of Travis County,
37 Texas, forfeit and pay to the State of Texas a sum not

1 to exceed \$5,000, which may be recovered in a civil
2 action by the commissioner.

3 . . .

4 Revisor's Note

5 V.T.I.C. Article 9.08 refers to the imposition of
6 a civil penalty on "proof . . . to the satisfaction
7 of" a district court of Travis County. The revised law
8 omits the reference because the procedures for
9 establishing proof in a court proceeding are
10 established under other law and it is not necessary to
11 restate those procedures in this revision.

12 Revisor's Note
13 (End of Subchapter)

14 V.T.I.C. Article 9.08, in part, authorizes the
15 commissioner of insurance to revoke the certificate of
16 authority of a company that violates that article. The
17 revised law omits that provision as unnecessary
18 because V.T.I.C. Article 9.28, revised in relevant
19 part as Section 2551.353 of this code, authorizes the
20 commissioner of insurance to revoke the certificate of
21 authority of a corporation that violates any provision
22 of Chapter 9, revised in this code as this title,
23 including Article 9.08. Also, Section 82.051 of this
24 code, which applies to a title insurance company,
25 authorizes the commissioner of insurance to revoke a
26 title insurance company's certificate of authority
27 after notice and an opportunity for a hearing if the
28 company violates this code. The omitted law reads:

29 Art. 9.08. . . .

30 The commissioner, upon giving thirty
31 (30) days' notice by registered mail, and
32 upon hearing had for that purpose, may
33 forfeit the Certificate of Authority to do
34 business of any company violating the
35 provisions of this Article 9.08.

36 [Sections 2502.006-2502.050 reserved for expansion]

37 SUBCHAPTER B. REBATES AND DISCOUNTS

38 Revised Law

39 Sec. 2502.051. REBATES AND DISCOUNTS PROHIBITED. A

1 commission, rebate, discount, portion of a title insurance premium,
2 or other thing of value may not be directly or indirectly paid,
3 allowed, or permitted by a person engaged in the business of title
4 insurance or received or accepted by a person for engaging in the
5 business of title insurance or for soliciting or referring title
6 insurance business. (V.T.I.C. Art. 9.30, Sec. A.)

7 Source Law

8 Art. 9.30. A. No commission, rebate, discount,
9 portion of any title insurance premium, or other thing
10 of value shall be directly or indirectly paid, allowed
11 or permitted by any person doing the business of title
12 insurance or received or accepted by any person for
13 doing the business of title insurance or for
14 soliciting or referring title insurance business.

15 Revised Law

16 Sec. 2502.052. CERTAIN DIVISIONS OF REAL PROPERTY CHARGES
17 PROHIBITED. Other than for services actually performed, a person
18 may not give or accept any portion, split, or percentage of a charge
19 made or received for a settlement or closing performed in
20 connection with a transaction involving the conveyance or
21 mortgaging of real property located in this state. (V.T.I.C. Art.
22 9.30, Sec. E.)

23 Source Law

24 E. No person shall give and no person shall
25 accept any portion, split, or percentage of any charge
26 made or received for the rendering of a real estate
27 settlement or closing in connection with a transaction
28 involving the conveyance or mortgaging of real estate
29 located in the State of Texas other than for services
30 actually performed.

31 Revisor's Note

32 Section E, V.T.I.C. Article 9.30, refers to the
33 performance of a "real estate settlement or closing"
34 in connection with a transaction involving certain
35 real property. The revised law omits "real estate" as
36 unnecessary because a settlement or closing performed
37 in connection with a transaction involving real
38 property is a "real estate" settlement or closing.

39 Revised Law

40 Sec. 2502.053. CERTAIN COMPENSATORY PAYMENTS NOT

1 PROHIBITED. This subchapter does not prohibit:

2 (1) payment for services actually performed by a title
3 insurance company, title insurance agent, or direct operation in
4 connection with title examination or with closing the transaction
5 or furnishing title evidence if:

6 (A) the payment does not exceed the percentage of
7 premium or other amount established by the commissioner for the
8 payment; and

9 (B) the person receiving the payment is licensed
10 as provided by this title;

11 (2) payment of bona fide compensation to a bona fide
12 employee principally employed by a title insurance company, title
13 insurance agent, or direct operation;

14 (3) reasonable payment for goods or facilities
15 actually provided and received; or

16 (4) payment for services actually performed by an
17 attorney in connection with title examination or with closing the
18 transaction, if the payment does not exceed a reasonable charge for
19 the services. (V.T.I.C. Art. 9.30, Secs. B (part), C.)

20 Source Law

21 B. This Article may not be construed as
22 prohibiting:

23 . . .
24 (2) payments for services actually
25 performed by a title insurance company, a title
26 insurance agent, or a direct operation, in connection
27 with closing the transaction, furnishing of title
28 evidence, or title examination, which payment may not
29 exceed the percentages of the premium or amounts
30 established by the commissioner for those payments; or

31 (3) payment of bona fide compensation to a
32 bona fide employee principally employed by a title
33 insurance company, direct operation, title insurance
34 agent, or other reasonable payment for goods or
35 facilities actually furnished and received; or

36 (4) payments for services actually
37 performed by an attorney in connection with title
38 examination or closing a transaction, which payment
39 may not exceed a reasonable charge for such services.

40 . . .
41 C. A person receiving any form of compensation
42 under Section B(2) of this Article must be licensed as
43 provided for under this Chapter.

44 Revised Law

45 Sec. 2502.054. CERTAIN DIVISIONS OF PREMIUMS NOT

1 PROHIBITED. (a) For purposes of this section, a subsidiary is a
2 company at least 50 percent of the voting stock of which is owned by
3 the title insurance company or by a wholly owned subsidiary of the
4 title insurance company.

5 (b) This subchapter does not:

6 (1) prohibit a title insurance company from:

7 (A) appointing as its title insurance agent for a
8 county a person who owns or leases and operates an abstract plant
9 for that county; and

10 (B) arranging for a division of premiums with the
11 agent as set by the commissioner; or

12 (2) affect the division of a premium between a title
13 insurance company and its subsidiary title insurance agent when the
14 company directly issues a title insurance policy or contract under
15 Section 2704.002. (V.T.I.C. Art. 9.30, Sec. B (part).)

16 Source Law

17 B. This Article may not be construed as
18 prohibiting:

19 (1) a foreign or domestic title insurance
20 company doing business in this state under this
21 Chapter, from appointing as its title insurance agent
22 pursuant to this Chapter a person owning or leasing and
23 operating an abstract plant of such county and making
24 the arrangement for division of premiums with the
25 agent as shall be set by the commissioner;

26 . . .
27 (5) Nothing in this article shall affect
28 the division of premium between a title insurance
29 company and its subsidiary title insurance agent when
30 the title insurance company directly issues its policy
31 or contract of title insurance pursuant to Article
32 9.34. For purposes of this provision, a subsidiary is
33 a company at least 50 percent of the voting stock of
34 which is owned by the title insurance company or by a
35 wholly owned subsidiary of the title insurance
36 company.
37 . . .

38 Revisor's Note

39 (1) Section B(1), V.T.I.C. Article 9.30, refers
40 to a title insurance company engaged in the business of
41 title insurance "in this state." The revised law omits
42 the quoted language as unnecessary because it is clear
43 from the context that the provision applies only to
44 title insurance companies engaged in the business of

1 title insurance in this state.

2 (2) Section B(1), V.T.I.C. Article 9.30, refers
3 to the appointment as title insurance agents of
4 certain persons "pursuant to this Chapter," meaning
5 V.T.I.C. Chapter 9, which is revised in this code as
6 this title. The revised law omits the quoted language
7 as unnecessary because Chapter 9 regulates the
8 appointment of title insurance agents without the need
9 for an additional statement to that effect. In
10 addition, the absence of the quoted language does not
11 imply that one can appoint a title insurance agent
12 under a provision of law other than a provision in
13 Chapter 9.

14 Revised Law

15 Sec. 2502.055. CERTAIN PROMOTIONAL AND EDUCATIONAL
16 ACTIVITIES NOT PROHIBITED. This subchapter does not prohibit
17 legal promotional and educational activities that are not
18 conditioned on the referral of title insurance business. (V.T.I.C.
19 Art. 9.30, Sec. B (part).)

20 Source Law

21 B. This Article may not be construed as
22 prohibiting:

23 . . .
24 (6) legal promotional and educational
25 activities that are not conditioned on the referral of
26 title insurance business.

27 Revised Law

28 Sec. 2502.056. MONETARY FORFEITURE. (a) A person who
29 pays or receives a commission, rebate, discount, or other thing of
30 value for soliciting or referring title insurance business in
31 violation of Section 2502.051 is engaging in the unauthorized
32 business of insurance.

33 (b) After notice and opportunity for hearing, a person who
34 makes or receives a payment described by Subsection (a) is liable
35 for a monetary forfeiture in an amount not less than the value of or
36 more than three times the value of the payment.

1 (c) A monetary forfeiture under Subsection (b) is in
2 addition to any other penalty provided by law. (V.T.I.C. Art. 9.30,
3 Sec. D.)

4 Source Law

5 D. The payment or receipt of a commission,
6 rebate, discount, or other thing of value to or by any
7 person for soliciting or referring title insurance
8 business in violation of this Article is engaging in
9 the unauthorized business of insurance, and in
10 addition to any other penalty, after notice and
11 opportunity for hearing, is subject to a monetary
12 forfeiture not less than the value nor more than three
13 times the value of the commission, rebate, discount,
14 or other thing of value.

15 [Chapters 2503-2550 reserved for expansion]

16 SUBTITLE B. ORGANIZATION OF TITLE INSURANCE COMPANIES

17 CHAPTER 2551. TITLE INSURERS

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20 Sec. 2551.002. APPLICABILITY OF LAW GOVERNING
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22 Sec. 2551.003. RULEMAKING; AUTHORITY OF DEPARTMENT AND
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24 [Sections 2551.004-2551.050 reserved for expansion]

25 SUBCHAPTER B. FORMATION

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32 Sec. 2551.056. REGULATION OF CERTAIN CORPORATIONS 1441

33 [Sections 2551.057-2551.100 reserved for expansion]

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12 CHAPTER 2551. TITLE INSURERS

13 SUBCHAPTER A. GENERAL PROVISIONS

14 Revised Law

15 Sec. 2551.001. APPLICABILITY OF TITLE AND OTHER LAW. (a)
16 Except as provided by Subsection (c) and unless the business of
17 title insurance or title insurance companies are expressly
18 mentioned, the provisions of this code other than this title do not
19 apply to:

20 (1) a corporation incorporated or engaging in business
21 exclusively under this title; or

22 (2) any title insurance business engaged in by a
23 corporation created under:

24 (A) Subdivision 57, Article 1302, Revised
25 Statutes;

26 (B) Chapter 861; or

27 (C) any other law.

28 (b) A law enacted after September 7, 1951, does not apply to
29 a title insurance company or title insurance business described by
30 Subsection (a) unless the law expressly states that it applies.

31 (c) To the extent applicable, the following provisions of
32 this code apply to a title insurance company:

33 (1) Articles 1.01, 1.04A, 1.09-1, 1.12, 1.13,
34 1.15-1.19, 21.31, 21.47, and 21.49-8;

- 1 (2) Subsection (b), Article 1.04D;
- 2 (3) Article 1.14-3, other than Section 8;
- 3 (4) Subchapter F, Chapter 5;
- 4 (5) Chapters 33, 82, 83, 84, 102, 261, 281, 541, 547,
- 5 555, 701, 801, 802, 824, and 828;
- 6 (6) Chapter 31, other than Section 31.005;
- 7 (7) Chapter 32, other than Section 32.022(b);
- 8 (8) Chapter 36, other than Sections 36.003, 36.004,
- 9 and 36.101-36.106;
- 10 (9) Subchapter A, Chapter 38;
- 11 (10) Subchapters A-G, Chapter 101;
- 12 (11) Chapter 982, other than Sections 982.003,
- 13 982.051, 982.101, 982.105, 982.106(b), 982.109, and 982.113; and
- 14 (12) Sections 37.052, 39.001, 39.002, 81.002, 81.004,
- 15 201.004, 201.005, 201.051, 201.055, 521.002-521.004, 805.021,
- 16 822.001, 822.051, 822.052(1), (2), and (3), 822.053, 822.057,
- 17 except Subsection (a)(4), 822.058, 822.059, 822.060, 822.155,
- 18 822.157, 822.158, except Subsection (a)(5), 841.004, 841.251,
- 19 841.252(a)-(c), and 4001.103.

20 (d) This title governs in any conflict between a provision
21 listed by Subsection (c) and a provision of this title.

22 (e) This title does not regulate the practice of law by an
23 attorney. The actions of an attorney in examining title or in
24 closing a real property transaction, regardless of whether a title
25 insurance policy is issued, does not constitute the business of
26 title insurance, unless the attorney elects to be licensed as an
27 escrow officer.

28 (f) Subsection (e) does not prohibit the commissioner from
29 promulgating a premium for title insurance. (V.T.I.C. Art. 9.22,
30 Sec. (b); Art. 9.47, Secs. 1, 2, 3.)

31 Source Law

32 [Art. 9.22]

33 (b) Each title insurance company is subject to
34 Articles 1.15 and 1.16 of this code.

35 Art. 9.47

1 those provisions relate to the state fire marshal and
2 have no relevance to title insurance companies.

3 In addition, the revised law omits the reference
4 to Section 15, Article 1.10, revised as part of Section
5 862.052 of this code. The relevant portion of Section
6 862.052 provides that a company authorized to write
7 life insurance may not write fire, marine, or inland
8 marine insurance, or any other insurance that may be
9 written by a fire and marine insurance company. A
10 title insurance company does not provide these types
11 of coverage.

12 In addition, the revised law omits the reference
13 to Article 1.14-2, revised as Chapters 225 and 981.
14 Article 1.14-2 relates to the provision of insurance
15 by eligible surplus lines insurers, which has no
16 relevance to title insurance companies.

17 In addition, the revised law omits the reference
18 to Articles 1.24B and 1.24C, revised as Subchapters C
19 and D, Chapter 38, of this code, as irrelevant to a
20 title insurance company. Subchapter C relates to a
21 data collection program relating to the effect of HIV
22 and AIDS on the availability, adequacy, and
23 affordability of health benefit plan coverage.
24 Subchapter D relates to closed claim reports for
25 specified liability insurers. A title insurance
26 company does not provide these types of coverage.

27 (3) Section 2, V.T.I.C. Article 9.47, provides
28 that "Article 2.01" applies to a title insurance
29 company where applicable. That article was revised by
30 the 77th Legislature as Sections 822.001, 822.051,
31 822.057 (part), 822.058-822.060, and 822.201 of this
32 code. The revised law omits the reference to Section
33 822.201 as irrelevant to a title insurance company.
34 Section 822.201 relates to capital and surplus

1 requirements for insurers authorized to write property
2 and casualty insurance in this state, and a title
3 insurance company does not provide that type of
4 insurance. Furthermore, other provisions in Section
5 2, V.T.I.C. Article 9.47, indicate that the
6 legislature did not intend to apply capital and
7 surplus requirements generally imposed under V.T.I.C.
8 Chapter 2 to title insurance companies. For example,
9 Section 2, V.T.I.C. Article 9.47, refers to the
10 applicability of "Article 2.02, Sections 1, 2 and 3,"
11 thereby expressly excluding the requirement of Section
12 4 of Article 2.02 relating to minimum capital stock and
13 surplus.

14 (4) Section 2, V.T.I.C. Article 9.47, provides
15 that "Article 2.02, Sections 1, 2 and 3," apply to a
16 title insurance company where applicable. Those
17 provisions were revised by the 77th Legislature as
18 Sections 822.052(1), (2), and (3), 822.053, and
19 822.202 of this code. The revised law omits the
20 reference to Section 822.202 of this code as
21 irrelevant to a title insurance company. Section
22 822.202 of this code relates to the treatment of full
23 coverage automobile insurance for certain regulatory
24 purposes, and a title insurance company does not
25 provide that type of insurance.

26 (5) Section 2, V.T.I.C. Article 9.47, provides
27 that "Article 21.43" applies to a title insurance
28 company where applicable. Article 21.43 was revised
29 by the 77th Legislature as Chapter 982 of this code.
30 Chapter 982 also contains material derived from
31 V.T.I.C. Subchapter B, Chapter 3, and V.T.I.C. Article
32 21.44. The revised law states that Chapter 982 applies
33 to a title insurance company, except that it excludes
34 specific sections within that chapter that are derived

1 exclusively from laws other than Article 21.43.
2 However, the revised law does not exclude Section
3 982.107, although Section 982.107 is derived from a
4 law other than Article 21.43. Section 982.107
5 provides only that Article 21.49-8 applies to a
6 foreign or alien insurance company. Under Article
7 9.47, revised in this section, Article 21.49-8 applies
8 to all title insurance companies. As a result,
9 including Section 982.107 as a provision applicable to
10 title insurance companies is merely redundant; stating
11 that Section 982.107 does not apply to title insurance
12 companies could create the false implication that
13 Article 21.49-8 does not apply to foreign or alien
14 title insurance companies.

15 (6) Section 3, V.T.I.C. Article 9.47, refers to
16 the State Board of Insurance. Chapter 685, Acts of the
17 73rd Legislature, Regular Session, 1993, abolished the
18 board and transferred its functions to the
19 commissioner of insurance and the Texas Department of
20 Insurance. Throughout this chapter, references to the
21 board have been changed appropriately.

22 Revised Law

23 Sec. 2551.002. APPLICABILITY OF LAW GOVERNING
24 CORPORATIONS. A title insurance company is subject to the Texas
25 Business Corporation Act, the Texas Miscellaneous Corporation Laws
26 Act (Article 1302-1.01 et seq., Vernon's Texas Civil Statutes), and
27 any other law of this state that governs corporations in general, to
28 the extent those laws are not inconsistent with this title.
29 (V.T.I.C. Art. 9.04.)

30 Source Law

31 Art. 9.04. The laws governing corporations in
32 general shall apply to and govern title insurance
33 companies insofar as same are not inconsistent with
34 the provisions of this Act.

1 Revisor's Note

2 V.T.I.C. Article 9.04 refers to "laws governing
3 corporations in general." For the convenience of the
4 reader, the revised law adds references to the Texas
5 Business Corporation Act and the Texas Miscellaneous
6 Corporation Laws Act (Article 1302-1.01 et seq.,
7 Vernon's Texas Civil Statutes), which are laws that
8 govern corporations in general.

9 Revised Law

10 Sec. 2551.003. RULEMAKING; AUTHORITY OF DEPARTMENT AND
11 COMMISSIONER. (a) The commissioner may adopt and enforce rules:

12 (1) that prescribe underwriting standards and
13 practices on which a title insurance contract must be issued;

14 (2) that define risks that may not be assumed under a
15 title insurance contract, including risks that may not be assumed
16 because of the insolvency of the parties to the transaction; and

17 (3) that the commissioner determines are necessary to
18 accomplish the purposes of this title.

19 (b) With respect to a company operating under this title
20 that engages in the kinds of business described by Section
21 2551.051(b)(1) or (2) in a manner that might subject the company to
22 another regulatory statute of this state, all examination and
23 regulation shall be exercised by the department rather than any
24 other state agency named in the other regulatory statute, as long as
25 the corporation engages in the business of title insurance.
26 (V.T.I.C. Art. 9.21.)

27 Source Law

28 Art. 9.21. (a) If any company operating under
29 the provisions of this Act shall engage in the
30 characters of business described in Subdivisions (1)
31 and (2) of Article 9.03 of this Act, in such manner as
32 might bring it within the provision of any other
33 regulatory statute now or hereafter to be in force
34 within the State of Texas, all examination and
35 regulation shall be exercised by the Board rather than
36 any other state agency which may be named in such other
37 laws, so long as such corporation engages in the title
38 guaranty or insurance business.

39 (b) The Board is hereby vested with power and
40 authority under this Act to promulgate and enforce

1 rules and regulations prescribing underwriting
2 standards and practices upon which title insurance
3 contracts are to be issued, and is hereby further
4 vested with the power and authority to define risks
5 which may not be assumed under title insurance
6 contracts, including risks that may not be assumed
7 because of the insolvency of the parties to the
8 transaction. In addition, the Board is hereby vested
9 with power and authority to promulgate and enforce all
10 other such rules and regulations which in the
11 discretion of the Board are deemed necessary to
12 accomplish the purposes of this Act.

13 Revisor's Note

14 (1) Section (a), V.T.I.C. Article 9.21, refers
15 to corporations engaging in a "title guaranty or
16 insurance business." The revised law omits the
17 reference to "title guaranty" because under V.T.I.C.
18 Article 9.02, revised in relevant part as Section
19 2501.005 of this title, the business of title
20 insurance is defined to include title guaranty.

21 (2) Section (b), V.T.I.C. Article 9.21, refers
22 to "rules and regulations." The revised law omits the
23 reference to "regulations" because under Section
24 311.005(5), Government Code (Code Construction Act), a
25 rule is defined to include a regulation. That
26 definition applies to the revised law.

27 [Sections 2551.004-2551.050 reserved for expansion]

28 SUBCHAPTER B. FORMATION

29 Revised Law

30 Sec. 2551.051. FORMATION; GENERAL PURPOSES AND POWERS. (a)
31 A private corporation may be created and licensed under this title
32 for the following purposes:

33 (1) to compile and own or lease, or to acquire and own
34 or lease, records or abstracts of title to real property or
35 interests in real property in this state or other jurisdictions, to
36 insure titles to that real property or interests in that real
37 property, and to indemnify the owners of that real property, or the
38 holders of interests in or liens on that real property, against loss
39 or damage resulting from an encumbrance on or defect in the title to
40 the real property or interests in the real property; and

1 to supervise or approve the signing of legal
2 instruments (but not the preparation of such
3 instruments) affecting land titles, disbursement of
4 funds, prorations, delivery of legal instruments,
5 closing of deals, issuance of commitments for title
6 insurance specifying the requirements for title
7 insurance and the defects in title necessary to be
8 cured or corrected. Nothing herein contained shall
9 authorize such corporation to practice law, as that
10 term is defined by the courts of this state, and in the
11 event of any conflict herein, this clause shall be
12 controlling.

13 (b) A corporation described by Subsection (a) of
14 this article may also exercise the following powers by
15 including same in the charter when filed originally,
16 or by amendment:

17 (1) To make and sell abstracts of title in
18 any counties of Texas or other states;

19 (2) To accumulate and lend money, to
20 purchase, sell or deal in notes, bonds, and
21 securities, but without banking privileges;

22 (3) To act as trustee under any lawful
23 trust committed to it by contract or will, appointment
24 by any court having jurisdiction of the subject matter
25 as trustee, receiver or guardian and as executor or
26 guardian under the terms of any will and as any
27 administrator of the estates of decedents under the
28 appointment of the court.

29 Revisor's Note

30 (1) Section (a), V.T.I.C. Article 9.03, refers
31 to "land" and "lands." For consistency throughout
32 this title, the revised law substitutes "real
33 property" for the quoted language. Under V.T.I.C.
34 Article 9.02, revised in this code as Section
35 2501.003, title insurance is defined for this title as
36 insurance that insures, guarantees, or indemnifies an
37 owner of real property, or another interested in the
38 real property, against certain losses. The revised
39 law is drafted accordingly.

40 (2) Section (b), V.T.I.C. Article 9.03, permits
41 a corporation to exercise certain powers by including
42 the powers in the corporation's charter "when filed
43 originally, or by amendment." The revised law omits
44 the quoted language as unnecessary because the revised
45 law does not otherwise express any kind of limit
46 regarding the manner of including the powers in the
47 charter.

48 (3) Section (b)(3), V.T.I.C. Article 9.03,

1 refers to a court "having jurisdiction of the subject
2 matter." Throughout this chapter, the revised law
3 omits the quoted language as unnecessary because the
4 general laws of civil jurisdiction determine which
5 courts have jurisdiction over the subject matter. For
6 example, see Sections 24.007-24.011, Government Code,
7 for the general jurisdiction of district courts.

8 Revised Law

9 Sec. 2551.052. NAME. (a) The name of a corporation
10 chartered or operating under this title may contain the words
11 "Title and Trust Company."

12 (b) The name of a corporation chartered or operating under
13 this title may not contain the word "Trust" alone. If the word
14 "Trust" appears in the corporation's letterhead or literature, the
15 corporation shall include the words "Without Banking Privileges."
16 (V.T.I.C. Art. 9.23.)

17 Source Law

18 Art. 9.23. Corporations chartered or operating
19 under the provisions of this Act may use in their
20 corporate name the words "Title and Trust Company" but
21 they shall not use the word "Trust" alone, and where
22 the word "Trust" appears, when in letterheads and
23 literature used by them, they shall print the words
24 "Without Banking Privileges."

25 Revised Law

26 Sec. 2551.053. STOCK AND SURPLUS REQUIREMENTS. (a) Except
27 as provided by Section 2552.053(b), a title insurance company must
28 have a paid-up capital of at least \$1 million and a surplus of at
29 least \$1 million.

30 (b) The capital stock and minimum surplus requirements of a
31 title insurance company must be maintained intact over and above
32 all outstanding liabilities, except contingent liabilities on
33 title insurance policies.

34 (c) If a title insurance company suffers the impairment of
35 its capital stock or minimum surplus requirements, the company
36 shall immediately report the impairment to the department.
37 (V.T.I.C. Arts. 9.06, 9.20.)

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Source Law

Art. 9.06. Except as provided by Article 9.56, Section 4A of this Chapter 9, all title insurance companies created and operating under the provisions of this Chapter must have a paid up capital of not less than One Million Dollars (\$1,000,000) and a surplus of not less than One Million Dollars (\$1,000,000).

Art. 9.20. The capital stock and minimum surplus requirement of every title insurance company, domestic or foreign, operating under the provisions of the Act must be maintained intact over and above all its outstanding liabilities, except contingent liabilities on policies of title insurance, and if such company shall suffer the impairment of its capital stock, or minimum surplus requirements it shall report such impairment forthwith to the Board.

Revisor's Note

V.T.I.C. Article 9.06 refers to "title insurance companies created and operating under the provisions of this Chapter," meaning Chapter 9, Insurance Code, revised as this title. V.T.I.C. Article 9.20 refers to a "title insurance company, domestic or foreign, operating under the provisions of the Act," meaning the Texas Title Insurance Act. Throughout this chapter, the revised law substitutes "title insurance company" for these references and other similar references. Under V.T.I.C. Article 9.10, revised as Section 2553.001(a) of this code, and Article 9.20, revised as Sections 2551.053(b) and (c) of this code, domestic and foreign title insurance companies are treated in the same manner and are subject to the same requirements. Furthermore, V.T.I.C. Article 9.02, revised as Section 2501.003 of this code, defines "title insurance company" to include both domestic and foreign companies operating under this title. That definition applies to the revised law.

Revised Law

Sec. 2551.054. PURCHASE OF OWN STOCK. (a) Subject to Section 2551.053(a) and the Texas Business Corporation Act, a title insurance company may purchase its own shares of stock. A purchase

1 of its own shares is not considered an investment and does not
2 constitute a violation of a provision of this code relating to
3 admissible investments.

4 (b) A title insurance company that purchases its own shares
5 must, not later than the 10th day after the date of purchase, file
6 with the commissioner a statement listing:

7 (1) the name of each shareholder from whom the shares
8 have been purchased; and

9 (2) the amount paid for the shares. (V.T.I.C.
10 Art. 9.06A.)

11 Source Law

12 Art. 9.06A. (a) Subject to Article 9.06 of
13 this Code and the Texas Business Corporation Act, a
14 title insurance company may purchase its own shares. A
15 purchase of its own shares is not considered an
16 investment and does not constitute a violation of the
17 provisions of this Code relating to admissible
18 investments.

19 (b) A company that purchases its own shares
20 shall, not later than the 10th (tenth) day after the
21 date of purchase, file a statement with the
22 Commissioner of Insurance listing the name of each
23 shareholder from whom the shares have been purchased
24 and the sum of money paid for those shares.

25 Revised Law

26 Sec. 2551.055. CHARTER OF CORPORATION ENGAGING IN BUSINESS
27 OF TITLE INSURANCE. (a) The incorporators of a corporation
28 engaging in the business of title insurance and incorporated under
29 this title, Subdivision 57, Article 1302, Revised Statutes, Chapter
30 40, Acts of the 41st Legislature, Regular Session, 1929 (Article
31 1302a, Vernon's Texas Civil Statutes), or any other law shall file
32 the corporation's original charter only with the department and
33 shall certify the charter only to the department.

34 (b) Only the department may collect from a company described
35 by this section any filing fees required by law.

36 (c) A corporation described by this section is not subject
37 to another law to the extent that the law conflicts with this
38 section. (V.T.I.C. Art. 9.14.)

39 Source Law

40 Art. 9.14. The original charter of corporations

1 doing the business of title insurance and incorporated
2 under the provisions of this Chapter, or under
3 Subdivision 57, Article 1302, Revised Civil Statutes
4 of 1925, or under Article 1302a, Texas Civil Statutes
5 (Acts 1929, 41st Legislature, page 383, Chapter 245,
6 Section 1) or under any other law regardless of the
7 nature of such amendment, shall be certified only to
8 and filed only with the Board, and only the Board shall
9 collect from the said companies filing fees required
10 under the law. All other laws or parts of laws, to the
11 extent that the same are in conflict with the
12 provisions of this Article, shall not hereafter apply
13 to such corporations.

14 Revisor's Note

15 V.T.I.C. Article 9.14 refers to an original
16 charter "regardless of the nature of such amendment."
17 The revised law omits the quoted language as obsolete.
18 Chapter 419, Acts of the 64th Legislature, Regular
19 Session, 1975, amended Article 9.14 to eliminate the
20 requirement that amendments to charters of certain
21 corporations be certified and filed in addition to
22 original charters.

23 Revised Law

24 Sec. 2551.056. REGULATION OF CERTAIN CORPORATIONS. (a) A
25 corporation incorporated under Subdivision 57, Article 1302,
26 Revised Statutes, before February 27, 1929, and engaging in
27 business in this state on February 27, 1929:

28 (1) may continue to engage in business;

29 (2) is subject to this title; and

30 (3) shall comply with the requirements of this title
31 regarding investments and deposits.

32 (b) A shareholder in a company acting under this title is
33 not liable in the event of default in the payment of any debt or
34 liability of the company beyond the shareholder's subscription for
35 stock. (V.T.I.C. Art. 9.32.)

36 Source Law

37 Art. 9.32. No corporation shall be chartered
38 under Subdivision 57, Article 1302, Revised Statutes
39 of Texas, 1925, but all corporations heretofore
40 incorporated and now doing business in Texas shall be
41 permitted to continue in business and shall be subject
42 to all the provisions of this Act, and such companies
43 shall be required to comply with the requirements of
44 this Act with reference to investments and deposits.

1 Stockholders in a company acting under this Act
2 shall not be liable in the event of default in the
3 payment of any debt or liability of such company beyond
4 their subscription for such stock.

5 Revisor's Note

6 (1) V.T.I.C. Article 9.32 provides that "[n]o
7 corporation shall be chartered under Subdivision 57,
8 Article 1302, Revised Statutes of Texas, 1925." The
9 revised law omits that prohibition as unnecessary
10 because Subdivision 57, Article 1302, Revised
11 Statutes, was repealed by Chapter 229, Acts of the 57th
12 Legislature, Regular Session, 1961.

13 (2) V.T.I.C. Article 9.32 refers to
14 corporations "heretofore incorporated," meaning
15 corporations incorporated before the effective date of
16 the article. The revised law substitutes "before
17 February 27, 1929," for "heretofore" because that is
18 the effective date of the article.

19 [Sections 2551.057-2551.100 reserved for expansion]

20 SUBCHAPTER C. AUTHORITY TO ENGAGE IN BUSINESS

21 Revised Law

22 Sec. 2551.101. CERTIFICATE OF AUTHORITY REQUIRED. A title
23 insurance company may not engage in the business of title insurance
24 in this state unless the company holds a certificate of authority
25 issued under this title. (V.T.I.C. Art. 9.15 (part).)

26 Source Law

27 Art. 9.15. . . . No title insurance company,
28 domestic or foreign, shall transact business under
29 this Chapter unless it shall hold a valid certificate
30 of authority.

31 Revisor's Note

32 (1) V.T.I.C. Article 9.15 refers to "business
33 under this Chapter," meaning business under this
34 title. Throughout this chapter, the revised law
35 substitutes "business of title insurance" for this
36 reference and other similar references because that is
37 the only kind of business referred to in this title.

1 (2) V.T.I.C. Article 9.15 refers to "business
2 under this Chapter," meaning the business of title
3 insurance. The revised law adds a reference to the
4 business of title insurance "in this state" for
5 clarity and consistency with other similar regulatory
6 provisions.

7 (3) V.T.I.C. Article 9.15 refers to a title
8 insurance company holding a valid certificate of
9 authority. The revised law omits "valid" as
10 unnecessary because the word does not add to the clear
11 meaning of the law. For example, a document purporting
12 to be a certificate of authority is no longer a
13 certificate of authority if it is expired and is not a
14 certificate of authority if it is a forgery.

15 Revised Law

16 Sec. 2551.102. ISSUANCE OF CERTIFICATE OF AUTHORITY. (a)
17 Subject to Subsection (c), the department shall issue a certificate
18 of authority to engage in the business of title insurance if,
19 following any examination the department considers proper, the
20 department makes a determination favorable to the title insurance
21 company with respect to:

22 (1) the payment of capital stock and surplus as
23 required by this title; and

24 (2) the value of the assets used to pay the capital
25 stock and surplus.

26 (b) The title insurance company shall pay the expense of any
27 examination conducted under Subsection (a).

28 (c) Issuance of a certificate of authority to a foreign
29 corporation is governed by Section 2553.001. (V.T.I.C. Art. 9.15
30 (part); New.)

31 Source Law

32 Art. 9.15. The Board after having satisfied
33 itself by such investigation as it may deem proper with
34 reference to the payment of capital stock and surplus
35 as required by this Chapter 9, and the value of the
36 assets offered in payment thereof (the expense of

1 which examination shall be borne by the title
2 insurance company), shall issue to such title
3 insurance company a certificate of authority to
4 transact the characters of business provided for in
5 this Chapter on either an annual or a continuing basis.
6 . . .

7 Revisor's Note

8 (1) V.T.I.C. Article 9.15 refers to a
9 certificate of authority issued "on either an annual
10 or a continuing basis." The revised law omits this
11 reference because under Section 1, V.T.I.C. Article
12 1.14, revised in relevant part as Section 801.053 of
13 this code and applicable to a title insurance company
14 under Section 2551.001, a certificate of authority is
15 valid until it is revoked or suspended. Section 2,
16 Chapter 194, Acts of the 56th Legislature, Regular
17 Session, 1959, amending Article 1.14, repealed "[a]ll
18 laws and parts of laws in conflict herewith . . . to
19 the extent that they require periodic renewal of
20 certificates of authority."

21 (2) For clarity and the convenience of the
22 reader, the revised law adds a reference to the
23 applicability of Section 2553.001 to a foreign
24 corporation that seeks to obtain a certificate of
25 authority.

26 [Sections 2551.103-2551.150 reserved for expansion]

27 SUBCHAPTER D. GENERAL POWERS AND DUTIES

28 Revised Law

29 Sec. 2551.151. ADMISSIBLE INVESTMENTS. (a) A title
30 insurance company shall hold all investments in cash or in the
31 following:

32 (1) an abstract plant or plants, provided that:

33 (A) the corporation is organized under this title
34 and has the right to engage in the business of title insurance;

35 (B) except as provided by Subsection (b), the
36 investment is not more than 50 percent of the corporation's capital
37 stock; and

1 (C) the valuation of the plant or plants is
2 approved by the department;

3 (2) securities described by Article 3.39 or
4 investments authorized for title insurance companies under the laws
5 of any other state in which the company is authorized to engage in
6 business;

7 (3) real property or any real property interest that
8 is:

9 (A) required for the company's convenient
10 accommodation in the transaction of business with reasonable regard
11 to future needs;

12 (B) acquired in connection with a claim under a
13 title insurance policy;

14 (C) acquired in satisfaction or on account of
15 loans, mortgages, liens, judgments, or decrees previously owed to
16 the company in the course of business;

17 (D) acquired in partial payment of the
18 consideration of the sale of real property owned by the company if
19 the transaction results in a net reduction in the company's
20 investment in real property; or

21 (E) reasonably necessary to maintain or enhance
22 the sale value of real property previously acquired or held by the
23 company under this subdivision;

24 (4) a first mortgage note secured by any of the
25 following, provided that the amount of the note does not exceed 80
26 percent of the appraised value of the security for the note:

27 (A) an abstract plant and connected personal
28 property in or outside this state;

29 (B) stock of a title insurance agent in or
30 outside this state;

31 (C) a construction contract to build an abstract
32 plant and connected personal property; or

33 (D) any two or more of the items listed in this
34 subdivision;

1 (5) the shares of any federal home loan bank in an
2 amount necessary to qualify for membership and any additional
3 amounts approved by the commissioner;

4 (6) foreign securities that are substantially of the
5 same kinds, classes, and investment grade as securities otherwise
6 qualified for investment under this section, provided that, unless
7 the investment is also qualified under Subdivision (2), the
8 aggregate amount of foreign investments made under this subdivision
9 does not exceed:

10 (A) five percent of the insurer's admitted assets
11 at the end of the preceding year;

12 (B) two percent of the insurer's admitted assets
13 at the end of the preceding year invested in the securities of all
14 entities domiciled in any one foreign country; and

15 (C) one-half of one percent of the insurer's
16 admitted assets at the end of the preceding year invested in the
17 securities of any one individual entity domiciled in a foreign
18 country;

19 (7) securities lending, repurchase, reverse
20 repurchase, and dollar roll transactions, as described by Section
21 4(q), Article 3.33; or

22 (8) money market funds, as described by Section 4(s),
23 Article 3.33.

24 (b) If a corporation maintains with the department a deposit
25 described by Subchapter E in the amount of \$100,000, the
26 corporation may invest more than 50 percent of the corporation's
27 capital stock under Subsection (a)(1), as considered necessary by
28 the corporation's board of directors.

29 (c) A corporation created or operating under this title may
30 own or acquire more than one abstract plant in any one county, but
31 only one abstract plant in any one county is admissible as an
32 investment under Subsection (a)(1).

33 (d) A title insurance company may not hold real property
34 acquired under Subsection (a)(3)(B), (C), or (D) for more than 10

1 years without written approval of the department.

2 (e) Any investment that does not qualify under this section
3 and was owned by the title insurance company on October 1, 1967,
4 continues to qualify.

5 (f) If any otherwise valid investment qualified under this
6 section exceeds in amount any of the limitations on investment
7 provided by this section, the investment is inadmissible only to
8 the extent that it exceeds the limitation. (V.T.I.C. Art. 9.18.)

9 Source Law

10 Art. 9.18. Investments of all title insurance
11 companies operating under the provisions of this Act
12 shall be held in cash or may be invested in the
13 following:

14 (a) Any corporation organized under this Act
15 having the right to do a title insurance business may
16 invest as much as 50 percent of its capital stock in an
17 abstract plant or plants, provided that the valuation
18 to be placed upon such plant or plants shall be
19 approved by the Board; provided, however, that if such
20 corporation maintains with the Board the deposit of
21 One Hundred Thousand Dollars (\$100,000) in securities
22 as provided in Article 9.12 of this Act, such of its
23 capital in excess of 50 percent, as deemed necessary to
24 its business by its board of directors may be invested
25 in abstract plants; and provided further, that a
26 corporation created or operating under the provisions
27 of this Act may own or acquire more than one abstract
28 plant in any one county but only one abstract plant in
29 any one county is admissible as an investment.

30 (b) Those securities set forth in Article 3.39,
31 Insurance Code, and in authorized investments for
32 title insurance companies under the laws of any other
33 state in which the affected company may be authorized
34 to do business from time to time.

35 (c) Real estate or any interest therein which
36 may be:

37 (1) required for its convenient
38 accommodation in the transaction of its business with
39 reasonable regard to future needs;

40 (2) acquired in connection with a claim
41 under a policy of title insurance;

42 (3) acquired in satisfaction or on account
43 of loans, mortgages, liens, judgments or decrees,
44 previously owing to it in the course of its business;

45 (4) acquired in part payment of the
46 consideration of the sale of real property owned by it
47 if the transaction shall result in a net reduction in
48 the company's investment in real estate;

49 (5) reasonably necessary for the purpose
50 of maintaining or enhancing the sale value of real
51 property previously acquired or held by it under
52 Subparagraphs (1), (2), (3) or (4) of this Section;
53 provided, however, that no title insurance company
54 shall hold any real estate acquired under
55 Subparagraphs (2), (3) or (4) for more than ten (10)
56 years without written approval of the Board.

57 (d) First mortgage notes secured by:

58 (1) abstract plants and connected

1 domestic and foreign, operating under the provisions
2 of this Act shall, on or before the first of March
3 every year, file with the commissioner a verified
4 statement, in such form as the commissioner may
5 require, setting forth the statement of the business
6 done by it during the preceding year, and the condition
7 of its affairs as of December 31st preceding.

8 Revised Law

9 Sec. 2551.153. FEES. The general laws applicable to
10 payment of a filing fee by a corporation having capital stock apply
11 to a corporation subject to this title. (V.T.I.C. Art. 9.13.)

12 Source Law

13 Art. 9.13. The general laws applicable to
14 payment of filing fees of corporations having capital
15 stock are hereby made applicable to corporations
16 coming under the provisions of this Chapter.

17 Revised Law

18 Sec. 2551.154. TRANSFER OF CERTAIN BUSINESS TO STATE BANKS
19 OR TRUST COMPANIES. (a) This section applies to a corporation
20 chartered under Section 2551.051, or its antecedents, Article 9.01,
21 Texas Insurance Code, or Chapter 40, Acts of the 41st Legislature,
22 Regular Session, 1929 (Article 1302a, Vernon's Texas Civil
23 Statutes), and empowered to act as:

24 (1) trustee under a lawful trust committed to the
25 corporation by contract or will or by appointment by a court as
26 trustee, receiver, or guardian; and

27 (2) executor or guardian under the terms of a will or
28 as an administrator of a decedent's estate under the appointment of
29 the court.

30 (b) A corporation described by Subsection (a) may transfer
31 and assign to one of the following entities all of the corporation's
32 fiduciary business in which the corporation is named or acts as
33 guardian, trustee, executor, or administrator or in any other
34 fiduciary capacity:

35 (1) a state bank created under Subtitle A, Title 3,
36 Finance Code, or a predecessor to that law; or

37 (2) a state trust company created under Chapter 181,
38 Finance Code, or a predecessor to that law.

39 (c) On a corporation's transfer or assignment to a state

1 bank or trust company under this section, the state bank or trust
2 company shall, without the necessity of any action in a court of
3 this state or any action by the creator or beneficiary of the trust
4 or estate:

5 (1) continue the guardianship, trust, executorship,
6 administration, or other fiduciary relationship related to the
7 trust or estate;

8 (2) perform all of the duties and obligations of the
9 corporation related to the trust or estate; and

10 (3) exercise any powers and authority:

11 (A) related to the trust or estate; and

12 (B) exercised by the corporation at the time of
13 the transfer or assignment.

14 (d) A transfer or assignment by a corporation under this
15 section is not a resignation or refusal by the corporation to act on
16 behalf of the guardianship, trust, executorship, administration,
17 or other fiduciary relationship.

18 (e) On a corporation's transfer or assignment to a state
19 bank or trust company under this section, the naming or designation
20 by a testator or the creator of a living trust of the corporation to
21 act as trustee, guardian, or executor or in any other fiduciary
22 capacity includes the naming or designation of the state bank or
23 trust company and authorizes the state bank or trust company to act
24 in that capacity. (V.T.I.C. Art. 9.05, Sec. 1 (part).)

25 Source Law

26 Art. 9.05

27 Sec. 1. Any corporation heretofore chartered
28 under the provisions of Article 9.03 of this Act, or
29 its antecedents, Article 9.01, Texas Insurance Code,
30 or Chapter 40, Acts, 41st Legislature, 1929 (codified
31 as Article 1302a, Vernon's Texas Civil Statutes),
32 having as one of its powers "to act as trustee under
33 any lawful trust committed to it by contract or will,
34 appointment by any court having jurisdiction of the
35 subject matter, as trustee, receiver or guardian and
36 as executor or guardian under the terms of any will and
37 as any administrator of the estates of decedents under
38 the appointment of the court" may transfer and assign
39 to a state bank created under the provisions of
40 Subtitle A, Title 3, Finance Code, or a predecessor of
41 that law, as amended, or to a state trust company
42 created under the provisions of Chapter 181, Finance

1 Code, or a predecessor of that law, as amended, all of
2 its fiduciary business in which such corporation is
3 named or acting as guardian, trustee, executor,
4 administrator or in any other fiduciary capacity,
5 whereupon said state bank or trust company shall,
6 without the necessity of any judicial action in the
7 courts of the State of Texas or any action by the
8 creator or beneficiary of such trust or estate,
9 continue the guardianship, trusteeship, executorship,
10 administration or other fiduciary relationship, and
11 perform all of the duties and obligations of such
12 corporation, and exercise all of the powers and
13 authority relative thereto now being exercised by such
14 corporation, and provided further that the transfer or
15 assignment by such corporation of such fiduciary
16 business being conducted by it under the powers
17 granted in its original charter, as amended, shall not
18 constitute or be deemed a resignation or refusal to act
19 upon the part of such corporation as to any such
20 guardianship, trust, executorship, administration, or
21 any other fiduciary capacity; and provided further
22 that the naming or designation by a testator or the
23 creator of a living trust of such corporation to act as
24 trustee, guardian, executor, or in any other fiduciary
25 capacity, shall be considered the naming or
26 designation of the state bank or trust company and
27 authorizing such state bank or trust company to act in
28 said fiduciary capacity. . . .

29 Revisor's Note

30 (1) V.T.I.C. Article 9.05 refers to any
31 "corporation heretofore chartered." Article 9.05 is
32 derived from Chapter 125, Acts of the 57th
33 Legislature, Regular Session, 1961. At the time of
34 enactment, it referred to "[a]ny corporation
35 heretofore chartered under the provisions of Article
36 9.01 . . . or its antecedent." The powers granted to
37 corporations under the original enactment expired on
38 April 30, 1962. Chapter 125 was codified as Article
39 9.05 by Chapter 219, Acts of the 60th Legislature,
40 Regular Session, 1967. At the time of the 1967
41 enactment, the law was updated to refer to a
42 corporation chartered under Article 9.03, as well as
43 antecedent laws. However, Article 9.05, as codified
44 and updated in 1967, continued to be subject to the
45 April 30, 1962, expiration contained in the original
46 enactment. Under Section 24, Chapter 1073, Acts of the
47 70th Legislature, Regular Session, 1987, the provision
48 containing the expiration was repealed. From this

1 legislative history, it is clear that the legislature
2 intended Article 9.05 to have continuing legal effect
3 and to apply to newly chartered corporations.
4 Accordingly, the revised law omits the reference to
5 "heretofore."

6 (2) V.T.I.C. Article 9.05 refers to Subtitle A,
7 Title 3, Finance Code, or a predecessor of that law,
8 "as amended," and to Chapter 181, Finance Code, or a
9 predecessor of that law, "as amended." The revised law
10 omits the quoted language as unnecessary because under
11 Section 311.027, Government Code (Code Construction
12 Act), unless expressly provided otherwise, a reference
13 to a statute applies to all reenactments, revisions,
14 or amendments of that statute.

15 (3) V.T.I.C. Article 9.05 refers to a "judicial
16 action in the courts of the State of Texas." The
17 revised law omits "judicial" as unnecessary because a
18 court action is necessarily a judicial action.

19 (4) V.T.I.C. Article 9.05 validated certain
20 transfers and assignments of fiduciary business that
21 were made before the effective date of that article.
22 The revised law omits this provision as executed
23 because the provision served its purpose on the day it
24 took effect. Section 311.031(a)(2), Government Code
25 (Code Construction Act), provides that the repeal of a
26 statute does not affect any validation previously made
27 under the statute. That section applies to the revised
28 law. The omitted law reads:

29 Art. 9.05
30 Sec. 1. . . . All transfers and
31 assignments of fiduciary business by such
32 corporations to a state bank or trust
33 company consistent with the provisions of
34 this Act are hereby validated.

35 [Sections 2551.155-2551.200 reserved for expansion]

1 SUBCHAPTER E. REQUIRED DEPOSIT

2 Revised Law

3 Sec. 2551.201. DEPOSIT REQUIRED; AMOUNT. (a) Except as
4 provided by Section 2551.202, a title insurance company shall
5 deposit and maintain in the state treasury, or other depository in
6 this state named by the company and approved by the department,
7 either:

8 (1) cash; or

9 (2) securities described by Section 2551.151.

10 (b) A title insurance company's deposit under this section
11 must be in an amount equal to the lesser of:

12 (1) one-fourth of the authorized capital of the
13 company; or

14 (2) \$100,000.

15 (c) A deposit under this section is for the benefit of all
16 policyholders. (V.T.I.C. Art. 9.12 (part).)

17 Source Law

18 Art. 9.12. All title insurance companies,
19 domestic and foreign, engaged in the title insurance
20 business must at all times have and keep on deposit
21 with the State Treasury or such other depository in the
22 State of Texas as may be named by such corporation and
23 approved by the Board, either cash or such securities
24 as are listed in Article 9.18 of this Act as approved
25 investments for title insurance companies, to an
26 amount equal to one-fourth of the authorized capital
27 of such corporation; provided, however, that such
28 deposit shall in no event exceed the sum of One Hundred
29 Thousand Dollars (\$100,000). . . . This deposit shall
30 be for the benefit of all policyholders. . . .

31 Revisor's Note

32 V.T.I.C. Article 9.12, revised in this
33 subchapter, requires a title insurance company to keep
34 a specified amount on deposit in the state treasury or
35 another depository named by "such corporation."
36 Article 9.12 subsequently makes additional related
37 references to a corporation. Throughout this
38 subchapter the revised law substitutes "title
39 insurance company" for "corporation" for consistency
40 and because, in context, it is clear that the term

1 "corporation" refers to a "title insurance company."

2 Revised Law

3 Sec. 2551.202. EXCEPTION: FOREIGN TITLE INSURANCE COMPANY.

4 (a) A foreign title insurance company is not required to make a
5 deposit under Section 2551.201 if the company has on deposit with
6 insurance regulatory bodies in the United States an aggregate
7 amount of deposit that:

8 (1) is equal to the amount required by Section
9 2551.201; and

10 (2) secures all policyholders of the company,
11 regardless of their location.

12 (b) The foreign title insurance company must file with the
13 department a certificate of deposit under the hand and seal of each
14 insurance regulatory body holding a deposit of the company.

15 (V.T.I.C. Art. 9.12 (part).)

16 Source Law

17 Art. 9.12. . . . If a foreign title insurance
18 company has on deposit with insurance regulatory
19 bodies in the United States sums aggregating the
20 amount of deposit required by this Article in such
21 manner as to secure all policyholders wherever
22 located, then no deposit shall be required in this
23 state, but a certificate of deposit under the hand and
24 seal of such insurance regulatory body or bodies with
25 whom the deposits have been made shall be filed with
26 the Board.

27 Revised Law

28 Sec. 2551.203. WITHDRAWAL AND SUBSTITUTION OF DEPOSIT. A
29 title insurance company may withdraw the deposit of securities made
30 under Section 2551.201, or any portion of the deposit, after
31 substituting other securities of a sufficient value to maintain the
32 amount of deposit required under that section. (V.T.I.C. Art. 9.12
33 (part).)

34 Source Law

35 Art. 9.12. . . . Such corporation, at its
36 option may withdraw from time to time such securities
37 or any part thereof, first having deposited in such
38 depository in lieu thereof other securities of
39 sufficient value to maintain the required
40 deposit. . . .

1 Revised Law

2 Sec. 2551.204. USE OF DEPOSIT. (a) Except as otherwise
3 provided by Subsection (e), a deposit made under this subchapter
4 may be used only to pay an obligation connected with title
5 insurance.

6 (b) On the insolvency or dissolution of a title insurance
7 company, the company's deposit shall be used to protect title
8 insurance policyholders even if no accrued title insurance claims
9 exist and other unpaid obligations do exist, except as permitted by
10 Subsection (e).

11 (c) A title insurance company's deposit must be applied to:

12 (1) the complete payment of any obligations and
13 liabilities of the company connected with title insurance business;
14 and

15 (2) the establishment of adequate reserves or
16 reinsurance to protect any subsequently accruing or maturing title
17 insurance obligations and liabilities.

18 (d) The amount, handling, and distribution of any reserves
19 required under Subsection (c)(2) are subject to the control and
20 discretion of the department and are reviewable in judicial
21 proceedings governed by rules applicable to review of rates under
22 Subchapters D and E, Chapter 2703.

23 (e) Any deposit amount remaining after payments under
24 Subsection (c) must be applied to:

25 (1) payment of other obligations and liabilities of
26 the title insurance company; or

27 (2) distribution to shareholders. (V.T.I.C.
28 Art. 9.12 (part).)

29 Source Law

30 Art. 9.12. . . . Funds deposited under this
31 provision shall never be used for the payment of any
32 obligation other than those connected with title
33 insurance, and in the event of the insolvency or
34 dissolution of a corporation, the fund hereby provided
35 shall be used to protect title insurance policyholders
36 even though there be no accrued title insurance claims
37 and even though there be unpaid obligations of other
38 sorts; provided, however, that same shall be applied

1 to the payment of other obligations and liabilities of
2 said corporation and/or distribution to stockholders
3 after complete payment of the obligations and
4 liabilities of the corporation connected with title
5 insurance business and the establishment of adequate
6 reserves or reinsurance for the protection of any
7 subsequently accruing or maturing title insurance
8 obligations and liabilities, the amount of such
9 reserves and the handling and distribution of same to
10 be subject to the control and discretion of the Board,
11 same to be reviewable in judicial proceedings to be
12 governed by like rules as are applicable to review of
13 rates under Article 9.07 of this Act. . . .

14 [Sections 2551.205-2551.250 reserved for expansion]

15 SUBCHAPTER F. RESERVES

16 Revised Law

17 Sec. 2551.251. STATUTORY PREMIUM RESERVE REQUIRED. (a)

18 Each domestic title insurer shall establish and maintain a
19 statutory premium reserve. The reserve is cumulative. The reserve
20 must consist of the amounts required under Sections
21 2551.252-2551.260 and must be established and maintained during the
22 period and for the uses and purposes provided by those sections.

23 (b) The reserve required under this section:

24 (1) is considered to be unearned portions of the
25 original premium; and

26 (2) must be charged as a reserve liability of the title
27 insurer in determining the insurer's financial condition.

28 (V.T.I.C. Art. 9.16, Sec. 1.)

29 Source Law

30 Art. 9.16

31 Sec. 1. (a) Each domestic title insurer doing
32 a title insurance business under this chapter shall
33 establish and maintain a statutory premium reserve
34 during the period and for the uses and purposes
35 provided by this article, which shall at all times and
36 for all purposes be deemed and shall constitute
37 unearned portions of the original premium, and shall
38 be charged as a reserve liability of that insurer in
39 determining its financial condition.

40 (b) The reserve required under Subsection (a) of
41 this section shall be cumulative. The reserve shall be
42 established and shall consist of the amounts required
43 under this article.

44 Revised Law

45 Sec. 2551.252. AMOUNTS ADDED TO RESERVE FOR CALENDAR YEAR

46 1997; REDUCTIONS. (a) The total charges of a domestic title
47 insurer for title insurance policies written or assumed on or after

1 January 1, 1997, and before January 1, 1998, are computed by adding
2 the following, as described in the insurer's annual statement:

3 (1) the direct premium written by the insurer;

4 (2) the escrow and settlement service fees paid
5 directly to and collected by the insurer;

6 (3) other title fees and service charges paid directly
7 to and collected by the insurer, including fees for closing
8 protection letters; and

9 (4) premiums for any reinsurance assumed by the
10 insurer, less premiums for reinsurance ceded by the insurer during
11 that year.

12 (b) The amount a domestic title insurer must set aside in
13 the statutory premium reserve for the 1997 calendar year is
14 computed by multiplying the total charges computed under Subsection
15 (a) by:

16 (1) 6-1/5 percent if the insurer had \$250 million or
17 more in direct premium written for the year 1996; or

18 (2) 3-1/2 percent if the insurer had less than \$250
19 million in direct premium written for the year 1996.

20 (c) A domestic title insurer shall reduce additions to the
21 statutory premium reserve set aside for title insurance policies
22 written or assumed during the year 1997 over a 20-year period
23 beginning in the year after the year in which the policies are
24 written or assumed, as provided by Subsection (d), by:

25 (1) 26 percent of the additions in the first year
26 following the year of addition;

27 (2) 20 percent of the additions in the second year
28 following the year of addition;

29 (3) 10 percent of the additions in the third year
30 following the year of addition;

31 (4) nine percent of the additions in the fourth year
32 following the year of addition;

33 (5) five percent of the additions in the fifth and
34 sixth years following the year of addition;

1 (6) three percent of the additions in the seventh,
2 eighth, and ninth years following the year of addition;

3 (7) two percent of the additions in the 10th through
4 14th years following the year of addition; and

5 (8) one percent of the additions in the last six years
6 of the 20-year period.

7 (d) A domestic title insurer shall make the annual
8 reductions under Subsection (c) in increments of one-fourth of the
9 appropriate percentage of the additions each on March 31, June 30,
10 September 30, and December 31 of each year. (V.T.I.C. Art. 9.16,
11 Sec. 2.)

12 Source Law

13 Sec. 2. (a) The total charges of a domestic
14 title insurer for title insurance policies written or
15 assumed on or after January 1, 1997, but before January
16 1, 1998, are computed by adding the following, as set
17 forth in the title insurer's annual statement:

18 (1) the direct premium written by the
19 title insurer;

20 (2) the escrow and settlement service fees
21 paid directly to and collected by the title insurer;

22 (3) other title fees and service charges
23 paid directly to and collected by the title insurer,
24 including fees for closing protection letters; and

25 (4) premiums for reinsurance assumed less
26 premiums for reinsurance ceded during the year.

27 (b) The amount a domestic title insurer must set
28 aside in the statutory premium reserve for the 1997
29 calendar year is computed by multiplying the total
30 charges computed under Subsection (a) of this section
31 by:

32 (1) 6 2/10 percent if the insurer had \$250
33 million or more in direct premium written for the year
34 1996; or

35 (2) 3 1/2 percent if the insurer had less
36 than \$250 million in direct premium written for the
37 year 1996.

38 (c) Additions to the statutory premium reserve
39 set aside for title insurance policies written or
40 assumed during 1997 shall be reduced over a 20-year
41 period beginning in the year after the year in which
42 the policies are written or assumed, as provided by
43 Subsection (d) of this section, by:

44 (1) 26 percent of the additions in the
45 first year succeeding the year of addition;

46 (2) 20 percent of the additions in the
47 second succeeding year;

48 (3) 10 percent of the additions in the
49 third succeeding year;

50 (4) nine percent of the additions in the
51 fourth succeeding year;

52 (5) five percent of the additions in the
53 fifth and sixth succeeding years;

54 (6) three percent of the additions in the
55 seventh, eighth, and ninth succeeding years;

1 (7) two percent of the additions in the
2 10th through 14th succeeding years; and

3 (8) one percent of the additions in the
4 last six years.

5 (d) The annual reductions under Subsection (c)
6 of this section shall be made in increments of
7 one-fourth of the appropriate percentage of the
8 additions each on March 31, June 30, September 30, and
9 December 31 of each year.

10 Revised Law

11 Sec. 2551.253. AMOUNTS ADDED TO RESERVE FOR CALENDAR YEARS
12 AFTER 1997; REDUCTIONS. (a) Out of total charges for title
13 insurance policies written or assumed on or after January 1, 1998, a
14 domestic title insurer shall add to and set aside in the statutory
15 premium reserve an amount equal to the total of the following, as
16 described in the insurer's annual statement:

17 (1) 25 cents per \$1,000 of net retained liability if
18 the insurer had \$250 million or more in direct written premiums
19 written for the most recent calendar year; or

20 (2) 30 cents per \$1,000 of net retained liability if
21 the insurer had less than \$250 million in direct written premiums
22 written for the most recent calendar year.

23 (b) A domestic title insurer shall reduce additions to the
24 statutory premium reserve set aside for title insurance policies
25 written or assumed after the year 1997 over a 20-year period
26 beginning in the year after the year in which the policies are
27 written or assumed in the manner and under the same percentages
28 applied under Sections 2551.252(c) and (d). (V.T.I.C. Art. 9.16,
29 Sec. 3.)

30 Source Law

31 Sec. 3. (a) Out of total charges for title
32 insurance policies written or assumed on or after
33 January 1, 1998, a domestic title insurer shall add to
34 and set aside in the statutory premium reserve an
35 amount equal to the total of the following as set forth
36 in the title insurer's annual statement:

37 (1) \$0.25 per \$1,000 of net retained
38 liability if the insurer had \$250 million or more in
39 direct written premiums written for the most recent
40 calendar year; or

41 (2) \$0.30 per \$1,000 of net retained
42 liability if the insurer had less than \$250 million in
43 direct written premiums written for the most recent
44 calendar year.

45 (b) Additions to the statutory premium reserve
46 set aside for title insurance policies written or

1 assumed after 1997 shall be reduced over a 20-year
2 period beginning in the year after the year in which
3 the policies are written or assumed in the manner and
4 under the same percentages applied under Sections 2(c)
5 and (d) of this article.

6 Revised Law

7 Sec. 2551.254. TRANSITIONAL RELEASE; TRANSITIONAL CHARGE.

8 (a) In addition to the requirements described by Sections 2551.252
9 and 2551.253, each domestic title insurer shall compute a total
10 statutory premium reserve balance for all policy years combined as
11 of December 31, 1996.

12 (b) A domestic title insurer shall compute the balance under
13 Subsection (a) as if Section 2551.252 were in effect during the
14 20-year period ending December 31, 1996. That balance, less the
15 total actual statutory premium reserve balance carried by the
16 insurer on December 31, 1996, is the insurer's transitional charge
17 if the resulting amount is more than zero or is the insurer's
18 transitional release if the resulting amount is zero or less.

19 (c) If a domestic title insurer has a transitional charge
20 under Subsection (b), in addition to any changes to the statutory
21 premium reserve otherwise required by this subchapter, the insurer
22 shall add to its statutory premium reserve, on December 31 of each
23 year for 10 consecutive years beginning on December 31, 1997, an
24 amount equal to one-tenth of the transitional charge.

25 (d) If a domestic title insurer has a transitional release
26 under Subsection (b), in addition to any changes to the statutory
27 premium reserve otherwise required by this subchapter, the insurer
28 shall reduce its statutory premium reserve, on December 31 of each
29 year for 10 consecutive years beginning on December 31, 1997, by an
30 amount equal to one-tenth of the transitional release. (V.T.I.C.
31 Art. 9.16, Sec. 4.)

32 Source Law

33 Sec. 4. (a) In addition to the requirements
34 imposed under Sections 2 and 3 of this article, each
35 domestic title insurer shall compute a total statutory
36 premium reserve balance for all policy years combined
37 as of December 31, 1996.

38 (b) The balance under Subsection (a) of this
39 section shall be computed as if Section 2 of this
40 article were in effect during the 20-year period

1 ending December 31, 1996. That balance, less the total
2 actual statutory premium reserve balance carried by
3 the insurer on December 31, 1996, is the insurer's
4 transitional charge if the resulting amount is greater
5 than zero or is the insurer's transitional release if
6 the resulting amount is zero or less.

7 (c) If the domestic title insurer has a
8 transitional charge under Subsection (b) of this
9 section, in addition to the changes to the statutory
10 premium reserve otherwise required by this article,
11 the domestic title insurer shall add to its statutory
12 premium reserve, on December 31 of each year for 10
13 consecutive years beginning on December 31, 1997, an
14 amount equal to one-tenth of the transitional charge.

15 (d) If the domestic title insurer has a
16 transitional release under Subsection (b) of this
17 section, in addition to the changes to statutory
18 premium reserve otherwise required by this article,
19 the domestic title insurer shall reduce its statutory
20 premium reserve, on December 31 of each year for 10
21 consecutive years beginning on December 31, 1997, by
22 an amount equal to one-tenth of the transitional
23 release.

24 Revised Law

25 Sec. 2551.255. RUNOFF BALANCE. (a) At the end of each
26 calendar year beginning in 1997, each domestic title insurer shall
27 compute a total statutory premium reserve balance for all policy
28 years before January 1, 1997, combined. The balance shall be
29 computed as of the year-end evaluation date and as if Section
30 2551.252 were in effect during the 20-year period ending December
31 31, 1996. The balance computed under this subsection is the runoff
32 balance.

33 (b) A domestic title insurer shall reduce its statutory
34 premium reserve by an amount equal to the difference between:

35 (1) the runoff balance computed under Subsection (a);
36 and

37 (2) the runoff balance computed for the preceding
38 calendar year.

39 (c) The reduction of the statutory premium reserve under
40 Subsection (b) is in addition to any other changes to the statutory
41 premium reserve required by this subchapter. (V.T.I.C. Art. 9.16,
42 Sec. 5.)

43 Source Law

44 Sec. 5. (a) At the end of each calendar year
45 beginning in 1997, each domestic title insurer shall
46 also compute a total statutory premium reserve balance
47 for all policy years before January 1, 1997, combined.

1 That balance shall be computed as of the year-end
2 evaluation date and as if Section 2 of this article
3 were in effect during the 20-year period ending
4 December 31, 1996. The balance computed under this
5 subsection is the runoff balance.

6 (b) The title insurer shall reduce its statutory
7 premium reserve by an amount equal to the difference
8 between the runoff balance computed under Subsection
9 (a) of this section and the runoff balance computed for
10 the preceding calendar year.

11 (c) The reduction of the statutory premium
12 reserve under Subsection (b) of this section is in
13 addition to any other changes to the statutory premium
14 reserve required by this article.

15 Revised Law

16 Sec. 2551.256. ACTUARIAL CERTIFICATION. (a) Each
17 domestic or foreign title insurer shall file annually with the
18 insurer's annual statement required under Section 2551.152 an
19 actuarial certification made by a member in good standing of the
20 American Academy of Actuaries.

21 (b) An actuarial certification must:

22 (1) conform to the annual statement instructions for a
23 title insurer adopted by the National Association of Insurance
24 Commissioners; and

25 (2) include the actuary's professional opinion of the
26 insurer's reserves as of the date of the annual statement.

27 (c) The reserves analyzed under this section must include
28 reserves for known claims, including adverse development on known
29 claims, and reserves for incurred but not reported claims.

30 (V.T.I.C. Art. 9.16, Secs. 6, 8 (part).)

31 Source Law

32 Sec. 6. (a) Each domestic and foreign title
33 insurer shall file annually with the annual statement
34 required under Article 9.22 of this code an actuarial
35 certification made by a member in good standing of the
36 American Academy of Actuaries.

37 (b) The actuarial certification must conform to
38 the annual statement instructions for title insurers
39 adopted by the National Association of Insurance
40 Commissioners and must include the actuary's
41 professional opinion of the insurer's reserves as of
42 the date of the annual statement. The reserves
43 analyzed under this section must include reserves for
44 known claims, including adverse development on known
45 claims, and reserves for incurred but not reported
46 claims.

47 Sec. 8. A foreign title insurer doing business
48 in this state shall be required to comply with the
49 provisions of Section 6 and . . . of this article.

1 Revised Law

2 Sec. 2551.257. SUPPLEMENTAL RESERVE. Each domestic or
3 foreign title insurer shall establish a supplemental reserve in an
4 amount equal to the amount by which the actuarially certified
5 reserves exceed the total of the known claim reserve and statutory
6 premium reserve as set forth in the insurer's annual statement
7 required under Section 2551.152. (V.T.I.C. Art. 9.16, Secs. 7(a),
8 8 (part).)

9 Source Law

10 Sec. 7. (a) Each domestic and foreign title
11 insurer shall establish a supplemental reserve in the
12 amount by which the actuarially certified reserves
13 exceed the total of the known claim reserve and
14 statutory premium reserve as set forth in the title
15 insurer's annual statement, subject to Subsection (b)
16 of this section.

17 Sec. 8. A foreign title insurer doing business
18 in this state shall be required to comply with the
19 provisions of . . . Section 7 of this article.

20 Revisor's Note

21 Section 7(b), V.T.I.C. Article 9.16, refers to a
22 process for phasing in supplemental reserve
23 requirements for a period ending December 31, 1998.
24 The revised law omits the language as executed. The
25 omitted law reads:

26 (b) The supplemental reserve
27 required under this section shall be phased
28 in as follows:

29 (1) 25 percent of the otherwise
30 applicable supplemental reserve is required
31 until December 31, 1996;

32 (2) 50 percent of the otherwise
33 applicable supplemental reserve is required
34 until December 31, 1997;

35 (3) 75 percent of the otherwise
36 applicable supplemental reserve is required
37 until December 31, 1998; and

38 (4) 100 percent of the
39 supplemental reserve is required after
40 December 31, 1998.

41 Revised Law

42 Sec. 2551.258. REEVALUATION OF CERTAIN RESERVE
43 REQUIREMENTS. The commissioner may reevaluate the adequacy of the
44 statutory premium reserves required under Section 2551.253 and may
45 make recommendations for legislative changes as the commissioner

1 considers appropriate. (V.T.I.C. Art. 9.16, Sec. 9.)

2 Source Law

3 Sec. 9. The commissioner may reevaluate the
4 adequacy of the statutory premium reserves required
5 under Section 3 of this article and may make
6 recommendations for legislative changes as the
7 commissioner considers appropriate.

8 Revised Law

9 Sec. 2551.259. STATUTORY PREMIUM RESERVE AND SUPPLEMENTAL
10 RESERVE FUND. The statutory premium reserve and supplemental
11 reserve fund shall be:

12 (1) held in cash; or

13 (2) invested in first mortgage notes or other
14 securities admissible for investment by title insurers under
15 Section 2551.151. (V.T.I.C. Art. 9.16, Sec. 10.)

16 Source Law

17 Sec. 10. The statutory premium reserve and
18 supplemental reserve fund shall be held in cash or
19 invested in first mortgage notes or other securities
20 admissible for investment by title insurers under
21 Article 9.18 of this code.

22 Revised Law

23 Sec. 2551.260. EFFECT OF INSOLVENCY OR DISSOLUTION. On the
24 insolvency or dissolution of a title insurer, the statutory premium
25 reserve and supplemental reserve fund shall be used to protect
26 title insurance policyholders, even if no accrued title insurance
27 claims exist and other unpaid obligations do exist. (V.T.I.C.
28 Art. 9.16, Sec. 11.)

29 Source Law

30 Sec. 11. In the event of the insolvency or
31 dissolution of a title insurer, the statutory premium
32 reserve and supplemental reserve fund shall be used to
33 protect title insurance contract holders, even if
34 there are no accrued title insurance claims and even if
35 there are unpaid obligations of other types.

36 Revisor's Note

37 Section 11, V.T.I.C. Article 9.16, refers to
38 title insurance "contract holders." The revised law
39 substitutes "policyholders" for "contract holders"
40 for consistency of terminology in this title.

1 Revised Law

2 Sec. 2551.261. RESERVE FOR UNPAID LOSSES AND LOSS
3 EXPENSES. (a) A title insurance company shall establish and
4 maintain, in addition to any other reserves, a reserve against:

5 (1) unpaid losses; and

6 (2) loss expense for costs of defense of an insured and
7 other costs expected to be paid to other parties in the defense,
8 settlement, or processing of a claim under the terms of a title
9 insurance policy.

10 (b) A title insurance company shall compute the amount of
11 the reserve required by this section by carefully estimating any
12 loss and loss expense likely to be incurred on a proper disposition
13 of each claim presented, under notice from or on behalf of the
14 insured, of a title defect in or lien or adverse claim against a
15 title insured by the company.

16 (c) The total expenses of the title insurance company are
17 equal to the estimate under Subsection (b) for payment of loss and
18 costs of defense of the insured and other costs expected to be paid
19 to other parties in the defense, settlement, or processing of the
20 claim under the terms of the title insurance policy. The title
21 insurance company shall revise the estimate at least annually and
22 may additionally revise the estimate as circumstances warrant.

23 (d) The amounts set aside in the reserve in any year shall be
24 deducted in determining the net profits for that year of any title
25 insurance company. (V.T.I.C. Art. 9.17.)

26 Source Law

27 Art. 9.17. (a) All title insurance companies
28 operating under the provisions of this Act shall at all
29 times establish and maintain, in addition to other
30 reserves, a reserve against (1) unpaid losses, and (2)
31 loss expense for costs of defense of the insured and
32 other costs expected to be paid to other parties in the
33 defense, settlement, or processing of the claim under
34 the terms of the title insurance policy, and shall
35 calculate such reserves by making a careful estimate
36 in each case of the loss and loss expense likely to be
37 incurred, by reason of every claim presented, pursuant
38 to notice from or on behalf of the insured, of a title
39 defect in or lien or adverse claim against the title
40 insured, that may result in a loss or cause expense to
41 be incurred for the proper disposition of the claim.

1 The sums of items so estimated for payment of loss and
2 costs of defense of the insured and other costs
3 expected to be paid to other parties in the defense,
4 settlement, or processing under the terms of the title
5 insurance policy shall be the total expenses of such
6 title insurance company.

7 (b) The amounts so estimated may be revised from
8 time to time as circumstances warrant, but shall be
9 redetermined at least once each year.

10 (c) The amounts set aside in such reserve in any
11 year shall be deducted in determining the net profits
12 for such year of any title insurance company.

13 [Sections 2551.262-2551.300 reserved for expansion]

14 SUBCHAPTER G. LIABILITY AND REINSURANCE

15 Revised Law

16 Sec. 2551.301. MAXIMUM POLICY LIABILITY. (a) Except as
17 provided by Subsection (b), a title insurance company may not issue
18 a title insurance policy on any real property located in this state
19 involving a potential policy liability of more than 50 percent of
20 the company's capital stock and surplus as stated in the most recent
21 annual statement of the company.

22 (b) A title insurance company may exceed the limit described
23 by Subsection (a) if the excess liability is reinsured in due course
24 in an authorized title insurance company. (V.T.I.C. Art. 9.19,
25 Sec. A (part).)

26 Source Law

27 Art. 9.19. A. No title insurance company
28 operating under the provisions of this Chapter shall
29 issue any policy of title insurance on any real
30 property located within the State of Texas involving a
31 potential liability by virtue of such policy of more
32 than fifty (50%) percent of the capital stock and
33 surplus as stated in the most recent annual statement
34 of the company unless the excess shall in due course be
35 reinsured in some other title insurance company
36 authorized to do business in Texas under this
37 Chapter. . . .

38 Revised Law

39 Sec. 2551.302. REQUIREMENTS FOR REINSURING POLICIES. A
40 title insurance company may reinsure any of its policies and
41 contracts issued on real property located in this state, if:

42 (1) the reinsuring title insurance company is
43 authorized to engage in business in this state under this title; and

44 (2) the department first approves the form of the
45 reinsurance contract. (V.T.I.C. Art. 9.19, Sec. A (part).)

1 Source Law

2 A. . . . Each title insurance company
3 authorized to do business under the provisions of this
4 Chapter may reinsure any or all of its policies and
5 contracts issued on real property situated within the
6 State of Texas, provided: (i) the reinsuring title
7 insurance company shall be licensed to do business in
8 the State of Texas under the provisions of this
9 Chapter; and (ii) the form of the reinsurance contract
10 shall be approved in advance by the Board.

11 Revisor's Note

12 Section A, V.T.I.C. Article 9.19, refers to a
13 "licensed" reinsuring title insurance company.
14 Throughout this chapter, the revised law substitutes
15 "authorized" for "licensed" for consistency with
16 terminology used throughout this code.

17 Revised Law

18 Sec. 2551.303. FORM OF REINSURANCE CONTRACT. (a) If the
19 department approves a form of reinsurance contract for a title
20 insurance company, the company may continue using the form without
21 submitting individual reinsurance contracts to the department for
22 approval.

23 (b) The department may alter the required form of a
24 reinsurance contract previously approved by the department after
25 first giving written notice to each title insurance company
26 affected by the alteration. (V.T.I.C. Art. 9.19, Sec. B.)

27 Source Law

28 B. If the Board has first approved one or more
29 forms of reinsurance contracts for a title insurance
30 company, such title insurance company may thereafter
31 continue using such form or forms without submitting
32 individual reinsurance contracts to the Board.
33 Authority is reserved to the Board, however, to alter
34 the required form so previously approved by it after
35 first giving written notice to the title insurance
36 company or title insurance companies affected by such
37 required change.

38 Revised Law

39 Sec. 2551.304. ACCEPTANCE OF REINSURANCE. A title
40 insurance company may accept a reinsurance risk on real property
41 located in this state only from an authorized title insurance
42 company. (V.T.I.C. Art. 9.19, Sec. C.)

1 Source Law

2 D. The Board may, however, upon application and
3 hearing permit any title insurance company licensed to
4 do business in this State under this Chapter to acquire
5 reinsurance upon an individual policy or facultative
6 basis from title insurance companies not licensed to
7 do business in this State, provided: (i) any such
8 non-admitted foreign title insurance company has a
9 combined capital and surplus of at least \$1,400,000
10 evidenced by its annual statement last preceding the
11 acceptance of such reinsurance; and (ii) any such
12 title insurance company so authorized to do business
13 under this Chapter has exhausted the opportunity to
14 acquire such reinsurance from all other title
15 insurance companies so authorized to do business under
16 the provisions of this Chapter.

17 E. The board may, however, upon application and
18 hearing, permit any title insurance company licensed
19 to do business in this state under this chapter and any
20 title insurance company authorized to reinsure
21 pursuant to the provisions of this chapter to retain an
22 additional potential liability of not more than 40
23 percent of the capital stock and surplus as stated in
24 the most recent annual statement of the company,
25 provided: (i) the title insurance company so
26 authorized to do business under this chapter has
27 exhausted the opportunity to acquire reinsurance
28 pursuant to Section D of this article; and (ii) the
29 additional potential liability is incurred only if the
30 loss suffered by the insured or insureds under the
31 policy or policies, and for which the insurer becomes
32 liable, exceeds the amount of insurance and
33 reinsurance authorized and accepted by the insurer and
34 other title insurance companies pursuant to the
35 provisions of Sections A, B, C, and D of this article.

36 Revisor's Note

37 Section E, V.T.I.C. Article 9.19, refers to
38 insurance and reinsurance "authorized and accepted" by
39 certain insurers. The revised law omits "authorized"
40 as included within the meaning of "accepted."

41 [Sections 2551.306-2551.350 reserved for expansion]

42 SUBCHAPTER H. ENFORCEMENT AND INTERVENTION

43 Revised Law

44 Sec. 2551.351. FORFEITURE OF RIGHT TO ENGAGE IN
45 BUSINESS. (a) A foreign or domestic corporation forfeits any
46 right to engage in business in this state if the corporation:

47 (1) issues any form of title insurance policy, or any
48 other adopted or approved form, on real property in this state other
49 than a form prescribed by the department;

50 (2) charges any premium rate on an owner, mortgagee,
51 or other title insurance policy, or on any other adopted or approved

1 form, on real property in this state other than a premium rate
2 prescribed by the commissioner; or

3 (3) otherwise engages in the business of title
4 insurance in relation to real property in this state on a form or
5 for a premium rate not prescribed by the department or
6 commissioner.

7 (b) This section does not apply to a premium rate charged in
8 connection with a reinsurance transaction between two or more title
9 insurance companies, provided that the reinsurance contract
10 complies with Subchapter G. (V.T.I.C. Art. 9.11.)

11 Source Law

12 Art. 9.11. Any foreign or domestic corporations
13 conducting the business of title insurance or issuing
14 any form of title insurance policy or other
15 promulgated or approved forms, or charging any premium
16 rates on an owner, mortgagee, or other title insurance
17 policy, or on other promulgated or approved forms,
18 except for the premium rates charged for reinsurance,
19 on Texas real property other than forms and premium
20 rates prescribed by the commissioner, under the
21 provisions of this Chapter shall forfeit its right to
22 do business in this state. The provisions of this
23 Article 9.11 shall not, however, be applicable to
24 premium rates charged in connection with reinsurance
25 transactions between or among title insurance
26 companies doing business under the provisions of this
27 Chapter, provided any such reinsurance contract
28 complies with the provisions of Article 9.19 of this
29 Chapter.

30 Revised Law

31 Sec. 2551.352. REVOCATION OF PERMIT AND FORFEITURE OF
32 CHARTER. (a) A domestic corporation engaged in the business of
33 title insurance that violates this title is subject to:

34 (1) revocation by the commissioner of the
35 corporation's permit; and

36 (2) forfeiture of the corporation's charter.

37 (b) A foreign corporation engaged in the business of title
38 insurance that violates this title is subject to revocation by the
39 commissioner of the corporation's permit. (V.T.I.C. Art. 9.33,
40 Sec. (a).)

41 Source Law

42 Art. 9.33. (a) The terms and provisions of
43 this Act are conditions upon which corporations doing

1 the business provided for in this Act may continue to
2 exist, and failure to comply with any of them or a
3 violation of any of the terms of this Act shall be
4 proper cause for revocation of the permit and
5 forfeiture of charter of a domestic corporation or the
6 permit of a foreign corporation.

7 Revised Law

8 Sec. 2551.353. PROCEDURE FOR REVOCATION OF
9 CERTIFICATE. (a) If the commissioner determines that a domestic
10 or foreign corporation that holds a certificate of authority to
11 engage in business in this state has violated this title, the
12 commissioner shall notify the company that the commissioner intends
13 to revoke the company's certificate of authority on the expiration
14 of the 30-day period following the date actual notice is delivered
15 or mailed under this section.

16 (b) Notice under this section must:

17 (1) be in writing; and

18 (2) be delivered to an executive officer of the
19 company by personal service or by registered mail.

20 (c) If a company receiving notice under this section does
21 not fully comply before the expiration of the period described by
22 Subsection (a), the commissioner shall revoke the company's
23 certificate of authority.

24 (d) A company whose certificate of authority is revoked
25 under this section is ineligible for another certificate of
26 authority until the later of:

27 (1) the date on which the company fully and in good
28 faith complies; or

29 (2) the first anniversary of the date of the
30 revocation. (V.T.I.C. Art. 9.28 (part).)

31 Source Law

32 Art. 9.28. If any corporation, domestic or
33 foreign, while holding a certificate of authority to
34 transact business in this state, shall fail or refuse
35 to comply with any of the provisions or requirements of
36 this Chapter, the Board, upon ascertaining this fact,
37 shall notify such company by actual notice in writing
38 delivered to an executive officer of such company, of
39 his intention to revoke its certificate of authority
40 to transact business in this state at the expiration of
41 thirty (30) days after the mailing of such registered
42 letter, or the date upon which such actual notice is

1 served. If such provisions or requirements are not
2 fully complied with upon the expiration of said thirty
3 (30) days, it shall be the duty of the Board to revoke
4 the certificate of authority of such company. In case
5 of such revocation, such company shall not be entitled
6 to receive another certificate of authority for a
7 period of one year, and until it shall have fully and
8 in good faith complied with all such provisions and
9 requirements of this Chapter. . . .

10 Revisor's Note

11 V.T.I.C. Article 9.28 permits a company to appeal
12 an action of the State Board of Insurance revoking the
13 company's certificate of authority. The revised law
14 omits the provision as unnecessary because the
15 provision is included in the general authority of a
16 company to appeal an action of the board under Section
17 (b), V.T.I.C. Article 9.33, revised as Section
18 2551.354, and Subchapter D, Chapter 36, of this code.
19 The omitted law reads:

20 Art. 9.28. . . . Any company feeling
21 itself aggrieved by the action of the Board
22 in revoking its certificate of authority to
23 do business in this state may bring suit
24 against it in Travis County, Texas, to annul
25 and vacate the order revoking such
26 certificate.

27 Revised Law

28 Sec. 2551.354. APPEAL OF COMMISSIONER ACTION. (a) A
29 company qualified or seeking to qualify under this title and
30 aggrieved by an action of the commissioner, including any action
31 against the company, may file an appeal of the commissioner's
32 action in a district court in Travis County.

33 (b) The appeal must be filed not later than the 30th day
34 after the date the commissioner issues the order or ruling, except
35 that if the order or ruling is directed against the company, whether
36 or not directed against any other party, the company has 30 days
37 after the date of receipt of official notice of the commissioner's
38 action to review the action.

39 (c) An appeal under this section is subject to the same
40 standard of review as an appeal under this code in accordance with
41 Section 36.203. (V.T.I.C. Art. 9.33, Sec. (b).)

1 Source Law

2 (b) Any company qualified or seeking to qualify
3 under this Act, feeling aggrieved by any action of the
4 Board, especially, but not limited to, any action
5 against such company, shall have the right to file a
6 suit in the District Court of Travis County, within
7 thirty (30) days after the Board has made its order or
8 ruling; provided, however, that if the order or ruling
9 is directed against such company, whether or not
10 directed against other companies, such company shall
11 have thirty (30) days after receipt of official notice
12 of such ruling from the Board to review such action of
13 the Board. Such cases shall be subject to the same
14 standard of review as other appeals under this code in
15 accordance with Article 1.04 of this code.

16 Revisor's Note

17 Section (b), V.T.I.C. Article 9.33, refers to an
18 action by the State Board of Insurance, "especially,
19 but not limited to" an action against a company. The
20 revised law substitutes "including" for "especially"
21 because, in context, the terms are synonymous. The
22 revised law omits "but not limited to" because Section
23 311.005(13), Government Code (Code Construction Act),
24 provides that "including" is a term of enlargement and
25 not of limitation and does not create a presumption
26 that components not expressed are excluded.

27 CHAPTER 2552. ATTORNEY'S TITLE INSURANCE COMPANIES AND TITLE
28 ATTORNEYS

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15 CHAPTER 2552. ATTORNEY'S TITLE INSURANCE COMPANIES

16 AND TITLE ATTORNEYS

17 SUBCHAPTER A. GENERAL PROVISIONS

18 Revised Law

19 Sec. 2552.001. PURPOSE; LEGISLATIVE INTENT. (a) Except
20 as otherwise expressly provided by this chapter, the purpose of
21 this chapter is to regulate an attorney's title insurance company
22 in the same manner as a title insurance company engaged in the
23 business of title insurance under this title.

24 (b) It is the express intent of the legislature to achieve
25 the purpose described by Subsection (a). (V.T.I.C. Art. 9.56, Sec.
26 1(d).)

27 Source Law

28 (d) It is the express intent of the Legislature
29 of the State of Texas that any such attorney's title
30 insurance company as and when created shall be
31 expressly regulated as are other title insurance
32 companies conducting the business of title insurance
33 under the provisions of this Chapter 9 of this
34 Insurance Code unless expressly provided in this
35 Article 9.56 to the contrary.

36 Revisor's Note

37 Section 1(d), V.T.I.C. Article 9.56, states that

1 "[i]t is the express intent of the Legislature of the
2 State of Texas that any such attorney's title insurance
3 company . . . be . . . regulated as are other title
4 insurance companies . . . unless expressly provided
5 . . . to the contrary." It is clear from the text of
6 the provision that the provision states the purpose of
7 V.T.I.C. Article 9.56, revised as this chapter, and
8 the revised law is drafted accordingly.

9 Revised Law

10 Sec. 2552.002. DEFINITIONS. In this chapter:

11 (1) "Attorney's title insurance" means:

12 (A) insurance that:

13 (i) insures, guarantees, or indemnifies an
14 owner of real property in this state, or another interested in the
15 real property, against loss or damage resulting from:

16 (a) a lien or encumbrance on or defect
17 in the title to the real property; or

18 (b) the invalidity of a lien on the
19 real property; and

20 (ii) is issued only in connection with and
21 as part of a real property transaction and a title opinion of a
22 title attorney; or

23 (B) any business that is substantially
24 equivalent to the insurance business described by Paragraph (A) and
25 is conducted in a manner designed to evade the provisions of this
26 title.

27 (2) "Attorney's title insurance company" means a
28 domestic company organized and operated in accordance with this
29 chapter for the business of attorney's title insurance.

30 (3) "Title attorney" means an attorney who satisfies
31 the requirements of this chapter to act as a title attorney in this
32 state for an attorney's title insurance company. (V.T.I.C.
33 Art. 9.56, Secs. 1(a), 2(a), (c), (d) (part), 3 (part); New.)

1 Source Law

2 Art. 9.56

3 Sec. 1. (a) This Article 9.56 authorizes,
4 under the limitations and express requirements as
5 herein contained, the incorporation and operation of
6 an "attorney's title insurance company."

7 Sec. 2. The following definitions shall be
8 applicable to this Article 9.56 of this Chapter 9, to
9 wit:

10 (a) "Attorney's title insurance" means
11 insuring, guaranteeing, or indemnifying owners of real
12 property or others interested therein against loss or
13 damage suffered by reason of liens, encumbrances upon,
14 or defects in the title to said property, and the
15 invalidity of liens thereon, issued only in connection
16 with and as a part of a real property transaction and
17 title opinion of a title attorney as the term "title
18 attorney" is defined herein, or doing any business in
19 substance equivalent to any of the foregoing in a
20 manner designed to evade the provisions of this
21 Chapter 9.

22 (c) "Attorney's title insurance company"
23 means any domestic company organized under the
24 provisions of this chapter for the business of
25 attorney's title insurance.

26 (d) "Title attorney" means any attorney
27 who [(1) is a member in good standing of the State Bar
28 of Texas; and (2) owns one or more shares of stock in
29 the attorney's title insurance company by which he is
30 appointed a title attorney under this section; and (3)
31 is actively engaged in the practice of law; and (4)
32 owns or leases and controls an abstract plant as
33 defined by the board, or is a participant in a bona
34 fide joint plant operation as defined by the board, or
35 has a contract to obtain title information from an
36 abstract plant licensed by the board . . . or who is
37 the appointed title attorney for an attorney's title
38 insurance company and bases his title opinion upon
39 title evidence furnished from an abstract plant
40 approved by the board and owned or leased and
41 controlled by such attorney's title insurance company,
42 except that in the event any attorney does not own or
43 lease and control a licensed abstract plant nor is a
44 participant in a bona fide joint plant operation and is
45 further unable to contract to obtain title information
46 from an abstract plant licensed by the board and
47 located in the county in which such attorney is a
48 resident, such attorney may satisfy the requirements
49 of this Subsection (4) by filing with the board
50 disclosure of the inability to obtain said contract as
51 a part of his license application upon a form
52 prescribed by the board so as to make such disclosure a
53 part of the application; and (5) is appointed as a
54 title attorney by an attorney's title insurance
55 company . . . and (6) is certified as such to the State
56 Board of Insurance; and (7) is licensed by the board as
57 a title attorney for such attorney's title insurance
58 company.]

59 Sec. 3. [Private corporations may be created by
60 15 or more State of Texas resident members of the State
61 Bar of Texas] to insure titles to lands or interest
62 therein in this state and indemnify the owners of such
63 lands, or the holders of interests in or liens on such
64 lands, against loss or damage on account of
65 encumbrances upon or defects in the title to such lands

1 or interests therein, provided that such title
2 insurance shall be issued only in connection with and
3 as a part of a title opinion of a title attorney,
4

5 Revised Law

6 Sec. 2552.003. APPLICABILITY OF TITLE 11. Except as
7 otherwise expressly provided by this chapter:

8 (1) this title applies to an attorney's title
9 insurance company;

10 (2) the provisions of this title that apply to a title
11 insurance company also apply to an attorney's title insurance
12 company;

13 (3) the provisions of this title that apply to a title
14 insurance agent also apply to a title attorney; and

15 (4) any rule adopted or premium promulgated by the
16 commissioner under this title applies to an attorney's title
17 insurance company and to a title attorney. (V.T.I.C. Art. 9.56,
18 Secs. 1(b), (c).)

19 Source Law

20 (b) All provisions of Chapter 9 of this
21 Insurance Code shall be applicable to such attorney's
22 title insurance company as may be so incorporated,
23 except as shall be otherwise expressly provided in
24 this Article 9.56. The provisions of this Chapter 9
25 which apply to title insurance companies shall also
26 apply to attorney's title insurance companies except
27 as otherwise expressly provided in this Article 9.56;
28 the provisions of this Chapter 9 which apply to title
29 insurance agents shall also apply to title attorneys,
30 except as otherwise expressly provided in this Article
31 9.56.

32 (c) Any rule, regulation, or promulgated
33 premium rate heretofore adopted by the State Board of
34 Insurance or hereafter adopted by the State Board of
35 Insurance under the provisions of Chapter 9 of this
36 Insurance Code shall likewise be applicable to any
37 such attorney's title insurance company and to any
38 title attorneys.

39 Revisor's Note

40 (1) Section 1(c), V.T.I.C. Article 9.56, refers
41 to "[a]ny rule [or] regulation." The revised law
42 omits the reference to "regulation" because under
43 Section 311.005(5), Government Code (Code
44 Construction Act), a rule is defined to include a
45 regulation. That definition applies to the revised

1 law.

2 (2) Section 1(c), V.T.I.C. Article 9.56, refers
3 to a "premium rate." The revised law substitutes
4 "premium" for "premium rate" because "premium" is
5 defined for purposes of this title by Section (o),
6 V.T.I.C. Article 9.02, revised in Section 2501.003 of
7 this code, to mean a premium rate.

8 (3) Section 1(c), V.T.I.C. Article 9.56, refers
9 to the State Board of Insurance. Chapter 685, Acts of
10 the 73rd Legislature, Regular Session, 1993, abolished
11 the board and transferred its functions to the
12 commissioner of insurance and the Texas Department of
13 Insurance, as appropriate. Throughout this chapter,
14 references to the board have been changed
15 appropriately.

16 Revised Law

17 Sec. 2552.004. BUSINESS OF ATTORNEY'S TITLE
18 INSURANCE. (a) The business of attorney's title insurance may be
19 engaged in only by an attorney's title insurance company through a
20 title attorney appointed by an attorney's title insurance company.

21 (b) For purposes of this chapter, a person engages in the
22 business of attorney's title insurance if the person:

23 (1) as insurer, guarantor, or surety, makes or
24 proposes to make a contract or policy of title insurance; or

25 (2) transacts or proposes to transact any phase of
26 title insurance, including:

27 (A) soliciting;

28 (B) negotiating before executing a title
29 insurance contract;

30 (C) executing a contract of title insurance; and

31 (D) insuring and transacting matters arising out
32 of the contract after the contract is executed, including
33 reinsurance.

34 (c) A person engages in the business of attorney's title

1 insurance if the person engages in or proposes to engage in any
2 business that is substantially equivalent to the business of
3 attorney's title insurance as part of a real property transaction
4 and title opinion of a title attorney in a manner designed to evade
5 the applicable provisions of this title. (V.T.I.C. Art. 9.56,
6 Secs. 2(b), 12 (part).)

7 Source Law

8 [Sec. 2]

9 (b) The "business of attorney's title
10 insurance" shall be conducted by and through a title
11 attorney, as herein defined, duly appointed by such
12 attorney's title insurance company and such business
13 of attorney's title insurance shall be deemed to be (1)
14 the making as insurer, guarantor, or surety, or
15 proposing to make as insurer, guarantor, or surety, of
16 any contract or policy of title insurance; (2) the
17 transacting or proposing to transact, any phase of
18 title insurance, including solicitation, negotiation
19 preliminary to execution, execution of a contract of
20 title insurance, insuring and transacting matters
21 subsequent to the execution of the contract and
22 arising out of it, including reinsurance; or (3) the
23 doing, or proposing to do, any business in substance
24 equivalent to any of the foregoing in a manner designed
25 to evade the provisions of this Chapter 9, all as a
26 part of a real estate transaction and title opinion of
27 a title attorney.

28 Sec. 12. The business of attorney's title
29 insurance shall only be conducted by attorney's title
30 insurance companies, as defined herein, and

31 Revised Law

32 Sec. 2552.005. OTHER TITLE INSURANCE COMPANIES AND AGENTS
33 PROHIBITED. A title insurance company, title insurance agent, or
34 escrow officer of a title insurance agent licensed under this title
35 to engage in the business of title insurance in this state may not
36 operate as an attorney's title insurance company or act as a title
37 attorney under this chapter. (V.T.I.C. Art. 9.56, Sec. 12 (part).)

38 Source Law

39 Sec. 12. . . . no title insurance company,
40 foreign or domestic, or title insurance agent or
41 escrow officer of a title insurance agent presently or
42 hereafter licensed to transact a title insurance
43 business in the State of Texas, pursuant to the
44 provisions of this Chapter 9 of this Insurance Code,
45 may operate as an attorney's title insurance company or
46 a title attorney under the provisions of this chapter.

47 Revisor's Note

48 Section 12, V.T.I.C. Article 9.56, refers to a

1 "foreign or domestic" title insurance company. The
2 revised law omits the reference to "foreign or
3 domestic" as unnecessary. Section (c), V.T.I.C.
4 Article 9.02, revised in Section 2501.003 of this
5 code, defines "title insurance company" for purposes
6 of this title to include both domestic and foreign
7 companies, and the revised law uses the defined term.

8 Revised Law

9 Sec. 2552.006. RECORD OF TITLE ATTORNEYS. The department
10 shall maintain a record of the name and address of each title
11 attorney in a manner that allows a person on request to conveniently
12 ascertain and inspect the title attorneys appointed by an
13 attorney's title insurance company authorized to engage in the
14 business of attorney's title insurance in this state. (V.T.I.C.
15 Art. 9.56, Sec. 6(b) (part).)

16 Source Law

17 (b) . . .
18 The board shall keep a record of the names and
19 addresses of all licensed title attorneys in such
20 manner that the title attorneys appointed by any
21 attorney's title insurance company authorized to
22 transact the business of an attorney's title insurance
23 company within the State of Texas may be conveniently
24 ascertained and inspected by any person upon request.

25 Revisor's Note

26 Section 6(b), V.T.I.C. Article 9.56, refers to a
27 record of "licensed" title attorneys. Throughout this
28 chapter, the revised law omits the reference to
29 "licensed" because "title attorney" is defined for
30 purposes of this chapter to mean an attorney who
31 satisfies the requirements of this chapter to act as a
32 title attorney, which include a requirement that the
33 attorney hold a title attorney's license issued under
34 this chapter.

35 Revised Law

36 Sec. 2552.007. OTHER PREMIUM OR FEE PROHIBITED. Attorney's
37 title insurance may not be issued for any premium or fee other than

1 the applicable prescribed premium as provided by Subchapters D and
2 E, Chapter 2703. (V.T.I.C. Art. 9.56, Sec. 3 (part).)

3 Source Law

4 Sec. 3. . . . [provided that such title
5 insurance shall be issued only in connection with and
6 as a part of a title opinion of a title attorney,]
7 without any premium or fee therefor except the
8 prescribed title insurance rates provided for in
9 Article 9.07 of this Chapter 9.

10 . . .

11 Revisor's Note

12 Section 3, V.T.I.C. Article 9.56, refers to the
13 "title insurance rates" under V.T.I.C. Article 9.07.
14 The revised law substitutes "premium" for "title
15 insurance rates" because Article 9.07, revised in
16 relevant part as Subchapters D and E, Chapter 2703, of
17 this code, requires the commissioner of insurance to
18 fix and promulgate "premium rates," and "premium" is
19 defined for purposes of this title by Section (o),
20 V.T.I.C. Article 9.02, revised in Section 2501.003 of
21 this code, to mean a premium rate.

22 [Sections 2552.008-2552.050 reserved for expansion]

23 SUBCHAPTER B. ORGANIZATION OF ATTORNEY'S TITLE INSURANCE COMPANY

24 Revised Law

25 Sec. 2552.051. ORGANIZING MEMBERS. Fifteen or more
26 members of the State Bar of Texas who are residents of this state
27 may organize a private corporation to act as an attorney's title
28 insurance company. (V.T.I.C. Art. 9.56, Sec. 3 (part).)

29 Source Law

30 Sec. 3. Private corporations may be created by 15
31 or more State of Texas resident members of the State
32 Bar of Texas

33 Revised Law

34 Sec. 2552.052. CAPITAL SHARE AND SURPLUS REQUIREMENTS
35 GENERALLY. (a) At the time of organization, an attorney's title
36 insurance company must have the capital and surplus required of a
37 title insurance company under Section 2551.053(a).

38 (b) The capital shares of an attorney's title insurance

1 company may be issued for a par value of \$100 or more per share and
2 in one or more classes.

3 (c) The capital shares, regardless of class, must be
4 subscribed and paid for and owned by and issued to licensed members
5 of the State Bar of Texas, each of whom is a resident of this state
6 and is qualified to be appointed a title attorney under this
7 chapter, subject to the right of reacquisition under Section
8 2552.054.

9 (d) Each certificate evidencing any share must have
10 endorsed on the certificate provisions relating to limitation on
11 the alienation of the shares indicating that the shares may be owned
12 only by qualifying attorneys or the attorney's title insurance
13 company issuing the shares.

14 (e) The requirements prescribed by Subsections (a), (c),
15 and (d) do not apply to an attorney's title insurance company
16 described by Section 2552.053 or to capital shares of an attorney's
17 title insurance company owned under that section. (V.T.I.C.
18 Art. 9.56, Secs. 3 (part), 4(b), 13(b).)

19 Source Law

20 Sec. 3. . . .

21 Subject to the provisions of Article 9.06 of this
22 Chapter 9, and Section 4 of this article, the capital
23 shares of such corporations may be issued for a par
24 value of \$100 or more per share, and in one or more
25 classes, provided, however, that (a) except as
26 provided in (b) hereafter, all such shares shall be
27 subscribed and paid for, and issued to members of the
28 State Bar of Texas, residing in the State of Texas,
29 subject to the right of reacquisition of such
30 shares

31 [Sec. 4]

32 (b) Any other attorney's title insurance company
33 shall meet the capital and surplus requirements upon
34 organization as required by Article 9.06 of this
35 Chapter 9.

36 [Sec. 13]

37 (b) The shares of stock of each attorney's title
38 insurance company (regardless of class) may be owned
39 only (except as provided in Section 3 of this Article
40 9.56) by attorneys duly licensed by the State Bar of
41 Texas, residing in the State of Texas, and qualified to
42 be appointed a title attorney under the provisions of
43 this Article 9.56. Each certificate evidencing any
44 share shall have endorsed thereon provisions relating
45 to limitation upon the alienation of such shares
46 whereby such shares may be owned only by such

1 qualifying attorneys or the attorney's title insurance
2 company so issuing such shares. The provisions of this
3 Section 13B shall not, however, be applicable to
4 shares owned by the organized State Bar of Texas, the
5 State Bar of Texas, or any foundation created by or
6 through the State Bar of Texas, whose purposes include
7 among others the continuing legal education of the
8 bench and bar of Texas.

9 Revised Law

10 Sec. 2552.053. CAPITAL SHARE AND SURPLUS REQUIREMENTS FOR
11 STATE BAR ENTITY. (a) An association of the organized State Bar
12 of Texas, the State Bar of Texas, or any foundation created by or
13 through the State Bar of Texas, the purposes of which include the
14 continuing legal education of the bench and bar of this state, may
15 own any class of capital shares of an attorney's title insurance
16 company if, at all times, at least 15 members of the State Bar of
17 Texas who are residents of this state own capital shares, whether or
18 not of the same class, in the attorney's title insurance company.

19 (b) An attorney's title insurance company created as an
20 affiliate or subsidiary of the organized State Bar of Texas, the
21 State Bar of Texas, or any foundation created by or through the
22 State Bar of Texas must have a paid-up capital of at least \$250,000
23 and a surplus of at least \$150,000. (V.T.I.C. Art. 9.56, Secs. 3
24 (part), 4(a).)

25 Source Law

26 Sec. 3. . . . (b) nothing herein contained
27 prohibits an association of the organized State Bar of
28 Texas, the State Bar of Texas, or any foundation
29 created by or through the State Bar of Texas, whose
30 purposes include among others the continuing legal
31 education of the bench and bar of Texas, from owning
32 shares of any class thereof, providing at least 15
33 resident members of the State Bar of Texas at all times
34 own shares therein, whether of the same class or not.

35 Sec. 4. (a) The attorney's title insurance
36 company created as an affiliate or subsidiary of the
37 organized State Bar of Texas, the State Bar of Texas,
38 or any foundation created by or through the State Bar
39 of Texas, and operating under the provisions of this
40 section, must have a paid-up capital of not less than
41 \$250,000 and a surplus of not less than \$150,000.

42 Revised Law

43 Sec. 2552.054. REACQUISITION OF SHARES. (a) The capital
44 shares of an attorney's title insurance company are subject to the
45 right of reacquisition of the shares by the attorney's title

1 insurance company in the event of:

2 (1) the death of the attorney shareholder;

3 (2) the failure of the attorney shareholder to remain
4 a licensed member of the State Bar of Texas; or

5 (3) the failure of the attorney shareholder to remain
6 appointed and qualified to be appointed a title attorney under this
7 chapter.

8 (b) An attorney's title insurance company must reacquire a
9 deceased attorney shareholder's shares within nine months of the
10 attorney shareholder's death. (V.T.I.C. Art. 9.56, Secs. 3 (part),
11 13(d).)

12 Source Law

13 Sec. 3. . . . subject to the right of
14 reacquisition of such shares by such corporation in
15 the event of death of such attorney shareholder or
16 failure of such attorney shareholder to be and remain a
17 licensed member of the State Bar of Texas, or failure
18 of such attorney shareholder to be and remain
19 qualified to be appointed a title attorney under the
20 provisions of this Article 9.56; and

21 [Sec. 13]

22 (d) In the event of the death of any title
23 attorney, the attorney's title insurance company shall
24 have a period of nine months following the death of
25 such title attorney within which to acquire such
26 deceased title attorney's share or shares.

27 Revisor's Note

28 Section 13(d), V.T.I.C. Article 9.56, refers to a
29 "title attorney" in the context of reacquisition of
30 the title attorney's capital shares in an attorney's
31 title insurance company in the event of the death of
32 the title attorney. The revised law substitutes
33 "attorney shareholder" for "title attorney" to provide
34 for consistent use of terminology in this section.

35 Revised Law

36 Sec. 2552.055. REACQUISITION PLAN REQUIRED. (a) As part
37 of the application for the approval of the charter of an attorney's
38 title insurance company, the applicants must file with the
39 department an acceptable plan providing for the reacquisition of
40 all shares of stock of the attorney's title insurance company

1 issued to a qualified attorney when the attorney is no longer
2 qualified to own the shares or on the death of the attorney.

3 (b) The plan must be approved by the department.

4 (c) In addition to other provisions, the plan must include
5 an express provision that the attorney's title insurance company
6 may not reacquire under any circumstance outstanding shares of its
7 stock as treasury stock if the reacquisition will result in
8 reducing its capital and surplus below the minimum capital and
9 surplus required for the initial organization of the attorney's
10 title insurance company. (V.T.I.C. Art. 9.56, Sec. 13(c).)

11 Source Law

12 (c) At time of organization of any attorney's
13 title insurance company, the applicants for such
14 attorney's title insurance company shall, as a part of
15 the application for granting and approving the charter
16 of such attorney's title insurance company, file with
17 and obtain the approval of the State Board of Insurance
18 an acceptable plan providing for the reacquisition of
19 any and all shares of stock of such attorney's title
20 insurance company issued to any qualified attorney
21 when such attorney no longer remains qualified to own
22 the same or upon the death of such attorney, whichever
23 shall first occur. Such plan shall, in addition to its
24 other provisions, contain an express provision that
25 under no circumstance may such attorney's title
26 insurance company acquire outstanding shares of its
27 stock as treasury stock if such reacquisition of such
28 shares will result in reducing the capital and surplus
29 of such attorney's title insurance company below the
30 minimum capital and surplus required for the initial
31 organization of such attorney's title insurance
32 company.

33 Revisor's Note

34 Section 13(c), V.T.I.C. Article 9.56, refers to
35 the "granting and approving" of a charter. The revised
36 law omits the reference to "granting" because the
37 granting of the charter is part of the approval
38 process.

39 Revised Law

40 Sec. 2552.056. INAPPLICABILITY OF LAWS REGULATING
41 SECURITIES. (a) All state laws, other than this title, that
42 provide for supervision, registration, or regulation in connection
43 with the sale, issuance, or offering of securities do not apply to
44 the sale, issuance, or offering of any capital stock to a person

1 authorized under this chapter to own the capital stock.

2 (b) The sale, issuance, or offering of any stock described
3 by this section is legal without any action or approval by any
4 official or state regulatory agency authorized to license,
5 regulate, or supervise the sale, issuance, or offering of
6 securities. (V.T.I.C. Art. 9.56, Sec. 13(a).)

7 Source Law

8 Sec. 13. (a) The sale, issuance, or offering
9 of any capital stock to persons permitted by the
10 provisions of this Article 9.56 to own such capital
11 stock are hereby exempted from all provisions of the
12 laws of this state, other than this Chapter 9, which
13 provide for supervision, registration, or regulation
14 in connection with the sale, issuance, or offering of
15 securities; and the sale, issuance, or offering of any
16 such capital stock to such persons shall be legal
17 without any action or approval whatsoever on the part
18 of any official or state regulatory agency authorized
19 to license, regulate, or supervise the sale, issuance,
20 or offering of securities.

21 [Sections 2552.057-2552.100 reserved for expansion]

22 SUBCHAPTER C. TITLE ATTORNEY'S LICENSE AND RENEWAL

23 Revised Law

24 Sec. 2552.101. LICENSE AND OTHER GENERAL REQUIREMENTS. To
25 act as a title attorney in this state for an attorney's title
26 insurance company, an attorney must:

27 (1) be a member in good standing of the State Bar of
28 Texas;

29 (2) own one or more shares of stock in the attorney's
30 title insurance company by which the attorney is appointed;

31 (3) be actively engaged in the practice of law;

32 (4) meet the requirements prescribed by this chapter
33 regarding an abstract plant;

34 (5) be appointed by an attorney's title insurance
35 company as its title attorney authorized by the attorney's title
36 insurance company to solicit insurance, collect premiums, and
37 issue or countersign policies on behalf of the attorney's title
38 insurance company;

39 (6) be certified as a title attorney to the
40 department;

1 (7) hold a license issued by the department under this
2 subchapter; and

3 (8) maintain a surety bond or deposit as required by
4 Section 2552.154. (V.T.I.C. Art. 9.56, Secs. 2(d) (part), 5
5 (part).)

6 Source Law

7 [Sec. 2]

8 [(d) "Title attorney" means any attorney
9 who] (1) is a member in good standing of the State Bar
10 of Texas; and (2) owns one or more shares of stock in
11 the attorney's title insurance company by which he is
12 appointed a title attorney under this section; and (3)
13 is actively engaged in the practice of law; and [(4)
14 owns or leases and controls] an abstract plant [as
15 defined by the board, or is a participant in a bona
16 fide joint plant operation as defined by the board, or
17 has a contract to obtain title information from an
18 abstract plant licensed by the board . . . , or who is
19 the appointed title attorney for an attorney's title
20 insurance company and bases his title opinion upon
21 title evidence furnished from an abstract plant
22 approved by the board and owned or leased and
23 controlled by such attorney's title insurance company,
24 except that in the event any attorney does not own or
25 lease and control a licensed abstract plant nor is a
26 participant in a bona fide joint plant operation and is
27 further unable to contract to obtain title information
28 from an abstract plant licensed by the board and
29 located in the county in which such attorney is a
30 resident, such attorney may satisfy the requirements
31 of this Subsection (4) by filing with the board
32 disclosure of the inability to obtain said contract as
33 a part of his license application upon a form
34 prescribed by the board so as to make such disclosure a
35 part of the application; and] (5) is appointed as a
36 title attorney by an attorney's title insurance
37 company . . . and authorized by such attorney's title
38 insurance company to solicit insurance and collect
39 premiums and to issue or countersign policies in its
40 behalf; and (6) is certified as such to the State Board
41 of Insurance; and (7) is licensed by the board as a
42 title attorney for such attorney's title insurance
43 company.

44 Sec. 5. No attorney shall act within this state
45 as a title attorney for an attorney's title insurance
46 company without first having been (1) licensed as a
47 title attorney for such company by the board and (2)
48 filing a bond or cash deposit in lieu thereof as
49 required in Section 9; and

50 Revisor's Note

51 Section 5, V.T.I.C. Article 9.56, refers to a
52 "cash" deposit filed in lieu of a bond as required in
53 Section 9 of that article. The relevant part of
54 Section 9 relating to bonds and deposits is revised in

1 this chapter as Section 2552.154. The revised law
2 omits "cash" because under that revised section the
3 alternatives to bonds include more than "cash"
4 deposits.

5 Revised Law

6 Sec. 2552.102. LICENSE APPLICATION. (a) Before an
7 initial license is issued to an attorney to act as a title attorney
8 in this state for an attorney's title insurance company, the
9 attorney's title insurance company must file an application for a
10 title attorney's license with the department on forms provided by
11 the department.

12 (b) The application must be:

13 (1) accompanied by a nonrefundable fee in an amount
14 not to exceed \$50 as prescribed by the department; and

15 (2) signed and sworn to by the attorney's title
16 insurance company and the proposed title attorney.

17 (c) The completed application must state that:

18 (1) the proposed title attorney:

19 (A) is a licensed attorney in this state and a
20 resident of this state;

21 (B) is actively engaged in the practice of law;

22 (C) is known to the attorney's title insurance
23 company:

24 (i) to have a good business reputation;

25 (ii) to be a current member, in good
26 standing, of the State Bar of Texas; and

27 (iii) to be worthy of the public trust; and

28 (D) meets the qualifications for a title attorney
29 as prescribed by this chapter; and

30 (2) the attorney's title insurance company does not
31 know of any fact or condition that would disqualify the proposed
32 title attorney from receiving a license. (V.T.I.C. Art. 9.56, Sec.
33 6(a) (part).)

1 satisfied.

2 (b) The department shall deliver the license to the
3 attorney's title insurance company for transmittal to the title
4 attorney. (V.T.I.C. Art. 9.56, Secs. 6(a) (part), (b) (part).)

5 Source Law

6 (a) . . .
7 The board shall grant such title attorney's
8 license if it determines from the application and its
9 own investigation that the foregoing requirements have
10 been met.

11 . . .
12 (b) . . . The board shall deliver such license
13 to the attorney's title insurance company for
14 transmittal to the title attorney.
15 . . .

16 Revised Law

17 Sec. 2552.104. DUPLICATE LICENSE. (a) The department
18 shall collect in advance a fee from a license holder who requests a
19 duplicate title attorney's license.

20 (b) The department shall prescribe the fee in an amount not
21 to exceed \$20. (V.T.I.C. Art. 9.56, Sec. 6(a) (part).)

22 Source Law

23 (a) . . .
24 The Commissioner of Insurance shall collect in
25 advance from such licensees requesting duplicate
26 licenses a fee not to exceed \$20. The State Board of
27 Insurance shall determine the amount of the fee.

28 Revised Law

29 Sec. 2552.105. LICENSE TERM. Unless a system of staggered
30 renewal is adopted under Section 4003.002, a title attorney's
31 license expires on June 1 following the date of issuance. (V.T.I.C.
32 Art. 9.56, Sec. 6(b) (part).)

33 Source Law

34 (b) . . .
35 Unless a system of staggered renewal is adopted
36 under Article 21.01-2 of this code and its subsequent
37 amendments, licenses shall continue until the first
38 day of the next June unless previously cancelled;
39

40 Revisor's Note

41 (1) Section 6(b), V.T.I.C. Article 9.56, refers
42 to Article 21.01-2 "and its subsequent amendments."
43 The revised law omits the quoted language in this

1 section and throughout this chapter because under
2 Section 311.027, Government Code (Code Construction
3 Act), unless expressly provided otherwise, a reference
4 to a statute applies to all reenactments, revisions,
5 or amendments of the statute. That provision applies
6 to the revised law.

7 (2) Section 6(b), V.T.I.C. Article 9.56,
8 provides that a title attorney's license expires on a
9 certain date "unless previously cancelled." The
10 revised law omits the quoted language as unnecessary
11 because cancellation of the license would cause the
12 license to no longer be valid, and thus the expiration
13 date would be rendered meaningless because of the
14 nature of the cancellation and not because of the
15 omitted statutory provision.

16 Revised Law

17 Sec. 2552.106. AUTOMATIC TERMINATION OF LICENSE. The
18 license of each title attorney appointed by an attorney's title
19 insurance company that surrenders its certificate of authority or
20 has its certificate revoked by the department is automatically
21 terminated without notice. (V.T.I.C. Art. 9.56, Sec. 6(b) (part).)

22 Source Law

23 (b) . . . provided, however, that if any
24 attorney's title insurance company surrenders or has
25 its certificate of authority revoked by the board, all
26 existing licenses of its title attorneys shall
27 automatically terminate without notice.

28 . . .

29 Revised Law

30 Sec. 2552.107. LICENSE SURRENDER OR FORFEITURE. (a) A
31 title attorney may voluntarily surrender the title attorney's
32 license at any time by giving notice to the department and to the
33 attorney's title insurance company.

34 (b) A title attorney automatically forfeits the title
35 attorney's license under the attorney's title insurance company if
36 the title attorney terminates the title attorney's relationship

1 with the attorney's title insurance company.

2 (c) A surrender or forfeiture of a title attorney's license
3 under this section does not affect the culpability of the license
4 holder for conduct committed before the effective date of the
5 surrender or forfeiture. The department may institute a
6 disciplinary proceeding against the former license holder for
7 conduct committed before the effective date of the surrender or
8 forfeiture. (V.T.I.C. Art. 9.56, Secs. 8(a), (f).)

9 Source Law

10 Sec. 8. (a) Any title attorney may surrender
11 the license at any time by giving notice to the board
12 and to the attorney's title insurance company
13 concerned. Any title attorney shall automatically
14 forfeit the license under the attorney's title
15 insurance company represented if the title attorney
16 terminates the title attorney's relationship with the
17 attorney's title insurance company.

18 (f) The voluntary surrender or automatic
19 forfeiture of a title attorney license to the
20 department under Subsection (a) of this section does
21 not affect the culpability of the license holder for
22 conduct of the license holder committed before the
23 effective date of the surrender or forfeiture, and the
24 commissioner may institute a disciplinary proceeding
25 against the license holder for conduct of the license
26 holder committed before the effective date of the
27 surrender or forfeiture.

28 Revised Law

29 Sec. 2552.108. CONTINUATION OF LICENSE. (a) Not later
30 than the 30th day after the date an attorney's title insurance
31 company terminates its contract with a title attorney or gives
32 notice of termination to the title attorney, the title attorney may
33 apply to the department for continuation of the title attorney's
34 license.

35 (b) The application must include an amendment to the license
36 stating the name of another attorney's title insurance company for
37 which the title attorney is or will be authorized to act. (V.T.I.C.
38 Art. 9.56, Sec. 6(c).)

39 Source Law

40 (c) If an attorney's title insurance company
41 terminates its contract with a title attorney or gives
42 notice of termination to the title attorney, then any
43 such title attorney may, within 30 days after either
44 occurrence apply to the board for continuation of his

1 license with an amendment thereto showing the name of
2 another attorney's title insurance company for whom he
3 is or will be authorized to act.

4 [Sections 2552.109-2552.150 reserved for expansion]

5 SUBCHAPTER D. TITLE ATTORNEY GENERAL REQUIREMENTS

6 Revised Law

7 Sec. 2552.151. CONTRACT REQUIRED FOR APPOINTMENT. (a) A
8 title attorney must be appointed by an attorney's title insurance
9 company by contract.

10 (b) The contract must make arrangements for division of
11 premium as may be approved by the department under this title.
12 (V.T.I.C. Art. 9.56, Sec. 2(d) (part).)

13 Source Law

14 [(d) "Title attorney" means any attorney
15 who . . . (5) is appointed as a title attorney by an
16 attorney's title insurance company] by contract making
17 such arrangements for division of premium as may be
18 approved by the board under this chapter

19 Revised Law

20 Sec. 2552.152. ABSTRACT PLANT REQUIREMENTS. (a) A title
21 attorney must:

22 (1) own or lease and control a licensed abstract
23 plant;

24 (2) participate in a bona fide joint abstract plant
25 operation;

26 (3) contract in accordance with this subchapter to
27 obtain title evidence from a licensed abstract plant; or

28 (4) use title evidence provided by an approved
29 abstract plant owned or leased and controlled by the attorney's
30 title insurance company.

31 (b) If at the time of applying for a license under Section
32 2552.102 an attorney does not own or lease and control a licensed
33 abstract plant, is not a participant in a bona fide joint abstract
34 plant operation, and is unable to contract to obtain title evidence
35 from a licensed abstract plant located in the county in which the
36 attorney resides, the attorney, as part of the license application,
37 may satisfy the requirements of this section by filing with the

1 department on a form prescribed by the department a disclosure of
2 the inability to obtain the contract. (V.T.I.C. Art. 9.56, Sec.
3 2(d) (part).)

4 Source Law

5 [(d) "Title attorney" means any attorney
6 who] . . . (4) owns or leases and controls an abstract
7 plant as defined by the board, or is a participant in a
8 bona fide joint plant operation as defined by the
9 board, or has a contract to obtain title information
10 from an abstract plant licensed by the board . . . , or
11 who is the appointed title attorney for an attorney's
12 title insurance company and bases his title opinion
13 upon title evidence furnished from an abstract plant
14 approved by the board and owned or leased and
15 controlled by such attorney's title insurance company,
16 except that in the event any attorney does not own or
17 lease and control a licensed abstract plant nor is a
18 participant in a bona fide joint plant operation and is
19 further unable to contract to obtain title information
20 from an abstract plant licensed by the board and
21 located in the county in which such attorney is a
22 resident, such attorney may satisfy the requirements
23 of this Subsection (4) by filing with the board
24 disclosure of the inability to obtain said contract as
25 a part of his license application upon a form
26 prescribed by the board so as to make such disclosure a
27 part of the application; and

28 Revisor's Note

29 (1) Section 2(d), V.T.I.C. Article 9.56, refers
30 to title "information." Throughout this chapter, the
31 revised law substitutes "evidence" for "information"
32 because the terms are synonymous in context and the
33 former is more commonly used.

34 (2) Section 2(d), V.T.I.C. Article 9.56, refers
35 to an abstract plant and a bona fide joint abstract
36 plant operation "as defined by the board" (now the
37 Texas Department of Insurance). The revised law omits
38 the quoted language because Section 2501.003 of this
39 code defines "abstract plant" and "joint abstract
40 plant operation" for purposes of this title to mean an
41 abstract plant or a joint abstract plant operation as
42 defined by the department.

43 Revised Law

44 Sec. 2552.153. CONTRACT WITH LICENSED ABSTRACT
45 PLANT. (a) A title attorney may enter into a contract with a

1 licensed abstract plant under which the abstract plant provides
2 title evidence to the title attorney. The contract must:

3 (1) be on a form prescribed by the commissioner; and
4 (2) state the standards for the evidence to be
5 provided.

6 (b) The commissioner may change the form of the contract.

7 (c) The parties to the contract shall determine the portion
8 of the premium to be paid by the title attorney to the licensed
9 abstract plant, subject to approval by the department.

10 (d) The department may disapprove any division of the
11 premium that the department determines to be excessive or
12 inadequate. The contract is considered to be approved as to the
13 division of the premium until the parties are notified of
14 disapproval by the department.

15 (e) The portion of the premium to be paid to the licensed
16 abstract plant is considered to be in compliance with Section
17 2502.053(1).

18 (f) The parties to the contract shall file with the
19 department a copy of the contract not later than the 10th day after
20 the date of execution of the contract. (V.T.I.C. Art. 9.56, Secs.
21 2(d) (part), 7(b).)

22 Source Law

23 [Sec. 2]

24 [(d) "Title attorney" means any attorney
25 who . . . has a contract to obtain title information
26 from an abstract plant licensed by the board] (which
27 said contract is upon the form promulgated by the board
28 and the portion of the premium to be paid to the owner
29 or the operator of said abstract plant has been
30 approved by the board)

31 [Sec. 7]

32 (b) The board shall, not later than January 1,
33 1976, promulgate the form of the contract to be made
34 and entered into between a title attorney and a
35 licensed abstract plant whereby title information
36 shall be furnished by a licensed abstract plant to a
37 title attorney. Such contract shall state therein the
38 standards for the information which is to be
39 furnished. Contracts shall be entered into between
40 each title attorney and each licensed abstract plant.
41 The board may from time to time alter, change, or amend
42 the form of such contract.

43 The parties to any such contract shall determine
44 the portion of the premium to be paid by the title

1 attorney to the licensed abstract plant, except that
2 the board is authorized to and may disapprove any
3 division of the premium which the board finds to be
4 excessive or inadequate. Such portion of the premium
5 to be paid to the licensed abstract plant shall be
6 deemed and considered as the "regular charge" for
7 title information as that term is used in Article 9.34
8 of this Chapter 9. Within 10 days following execution,
9 the parties to each such contract shall file a copy of
10 the executed contract with the board. Each such
11 contract shall be deemed to be approved as to the
12 division of the premium until the parties are notified
13 of disapproval by the board.

14 Revisor's Note

15 (1) Section 7(b), V.T.I.C. Article 9.56, refers
16 to the promulgation of a contract form "not later than
17 January 1, 1976." The revised law omits the reference
18 to the date because that provision is executed.

19 (2) Section 7(b), V.T.I.C. Article 9.56,
20 authorizes the board (now the commissioner of
21 insurance) to change the form of a contract "from time
22 to time." The revised law omits the quoted language
23 because, without an express limitation, the authority
24 to change the form of a contract includes the authority
25 to make the change at any time.

26 (3) Section 7(b), V.T.I.C. Article 9.56, refers
27 to the authority to "alter, change, or amend" a
28 contract form. The revised law omits the references to
29 "alter" and "amend" because their meanings are
30 included within the meaning of "change."

31 (4) Section 7(b), V.T.I.C. Article 9.56,
32 provides that the "portion of the premium to be paid to
33 the licensed abstract plant shall be deemed and
34 considered as the 'regular charge' for title
35 information as that term is used in Article 9.34 of
36 this Chapter 9," revised as Subchapter A, Chapter
37 2704, of this code. When originally enacted, V.T.I.C.
38 Article 9.34 referred to an abstract plant that
39 refused to provide title evidence at its "regular
40 charge." Since its enactment, Article 9.34 has been

1 amended and now refers to the refusal to provide title
2 evidence in compliance with V.T.I.C. Article
3 9.30(B)(2). Section B(2), Article 9.30, revised as
4 Section 2502.053(1) of this code, limits payments for
5 services performed in connection with providing title
6 evidence to certain amounts. Accordingly, the revised
7 law provides that the portion of the premium to be paid
8 to the abstract plant is considered to be in compliance
9 with Section 2502.053(1) instead of providing that the
10 portion of the premium is considered to be the "regular
11 charge."

12 Revised Law

13 Sec. 2552.154. BOND OR DEPOSIT REQUIRED. (a) A title
14 attorney shall make, file, and pay for a surety bond payable to the
15 department in the amount of \$7,500 and issued by a corporate surety
16 company authorized to write surety bonds in this state. The bond
17 shall obligate the principal and surety to pay any pecuniary loss
18 that is incurred by:

19 (1) a participant in a real property settlement or
20 closing in which an attorney's title insurance policy is issued by
21 the title attorney and that is sustained through an act of fraud,
22 dishonesty, theft, embezzlement, or wilful misapplication by a
23 title attorney; and

24 (2) any party to an escrow agreement in which the title
25 attorney is escrowee and that is sustained through an act of fraud,
26 dishonesty, forgery, theft, embezzlement, or wilful misapplication
27 by the title attorney, either directly and alone or in conspiracy
28 with another person.

29 (b) Instead of a surety bond, a title attorney may deposit
30 with the department cash or securities approved by the department
31 in the amount of \$7,500, subject to the same conditions required for
32 the bond. (V.T.I.C. Art. 9.56, Sec. 9(a).)

33 Source Law

34 Sec. 9. (a) Every attorney who has been

1 licensed as a title attorney shall make, file, and pay
2 for a surety bond with a corporate surety company
3 authorized to write surety bonds in this state,
4 payable to the State Board of Insurance in the sum of
5 \$7,500, which bond shall obligate the principal and
6 surety to (1) pay such pecuniary losses as may result
7 to any participant in a real estate settlement or
8 closing where an attorney's title insurance policy is
9 issued by such title attorney which shall be sustained
10 through acts of fraud, dishonesty, theft,
11 embezzlement, or wilful misapplication on the part of
12 any title attorney, (2) to pay such pecuniary loss as
13 any party to an escrow agreement in which the title
14 attorney is escrowee shall sustain through acts of
15 fraud, dishonesty, forgery, theft, embezzlement, or
16 wilful misapplication on the part of such title
17 attorney, either directly and alone, or in connivance
18 with others. In lieu of such bond any title attorney
19 may deposit with the board cash (or securities
20 approved by the board) which cash and securities shall
21 be in the amount of \$7,500 and subject to the same
22 conditions as provided for in said bond.

23 Revised Law

24 Sec. 2552.155. EXAMINATION OF LOSS COVERED BY
25 BOND. (a) At any time it appears that the terms of a title
26 attorney's bond may have been violated, the department may require
27 the title attorney to appear in Travis County, with records the
28 department determines to be proper, for an examination.

29 (b) The department shall specify a date for the examination
30 that is not earlier than the 10th day or later than the 15th day
31 after the date of service of notice of the requirement to appear.

32 (c) If after the examination the department determines that
33 the terms of the bond have been violated, the department shall
34 immediately notify the surety and prepare a written statement of
35 the facts of the loss and deliver the statement to the attorney
36 general. (V.T.I.C. Art. 9.56, Sec. 9(b) (part).)

37 Source Law

38 (b) If at any time it appears to the board that
39 the terms of any title attorney's bond may have been
40 violated, the board may require the title attorney to
41 appear in Travis County with such records as the board
42 deems proper on a named date not earlier than 10 days
43 nor later than 15 days from service of notice, and
44 there conduct an examination into the matter. If upon
45 such examination the board is satisfied that the terms
46 of said bond have been violated, the board shall
47 immediately notify the surety and prepare a written
48 statement covering the facts and deliver it to the
49 Attorney General of Texas,

1 attorney's title insurance company; and (2) such title
2 attorney bases each title opinion upon separate and
3 current title evidence furnished by a licensed
4 abstract plant of the records of the county in which
5 the real property, the title to which is to be insured,
6 is located; and (3) if such title attorney does not own
7 or lease and control a licensed abstract plant and does
8 not participate in a bona fide joint plant operation,
9 such title attorney pays to the licensed abstract
10 plant furnishing the title information the portion of
11 the premium which may be agreed upon between the title
12 attorney and the licensed abstract plant and approved
13 by the board under the contract to furnish title
14 information provided for under Paragraph (b) of this
15 Section 7.

16 Revised Law

17 Sec. 2552.158. AUTHORITY TO DELIVER BUT NOT ISSUE
18 POLICY. A title attorney may deliver, but not issue, a title
19 insurance policy in conformity with Subchapter A, Chapter 2704, if:

20 (1) the title attorney does not own or lease and
21 control a licensed abstract plant, is not a participant in a bona
22 fide joint abstract plant operation, and is unable to contract with
23 a licensed abstract plant to obtain the required title evidence in
24 the county in which the real property, the title to which is to be
25 insured, is located; or

26 (2) the title insurance policy is based on a certified
27 abstract of title prepared by a licensed abstract plant covering
28 the particular real property from the sovereignty of the soil to the
29 date of the transaction. (V.T.I.C. Art. 9.56, Sec. 7(c).)

30 Source Law

31 (c) In the event a title attorney does not own or
32 lease and control a licensed abstract plant nor is a
33 participant in a bona fide joint plant operation and is
34 unable to contract with a licensed abstract plant to
35 obtain the required title information in the county in
36 which the real property, the title to which is to be
37 insured, is located, such title attorney may deliver
38 (but not issue) title insurance policies in conformity
39 with the provisions of Article 9.34 of this Chapter 9.
40 Likewise, a title attorney may deliver (but not issue)
41 a title insurance policy upon real property in
42 conformity with the provisions of Article 9.34 of this
43 Chapter 9 when based upon a duly certified abstract of
44 title prepared by a licensed abstract plant covering
45 the particular real property from the sovereignty of
46 the soil to the date of the transaction.

47 [Sections 2552.159-2552.200 reserved for expansion]

1 SUBCHAPTER E. POWERS AND DUTIES OF ATTORNEY'S TITLE INSURANCE

2 COMPANIES

3 Revised Law

4 Sec. 2552.201. ACTING AS TITLE ATTORNEY. An attorney's
5 title insurance company may not permit an attorney to act as its
6 title attorney in this state, including by writing, signing, or
7 delivering title insurance policies, unless the attorney holds a
8 license issued under Subchapter C and maintains a surety bond or
9 deposit as required by Section 2552.154. (V.T.I.C. Art. 9.56,
10 Secs. 5 (part), 6(b) (part).)

11 Source Law

12 Sec. 5. . . . no attorney's title insurance
13 company shall allow or permit any attorney to act as
14 its title attorney within the state unless said
15 attorney shall first have obtained a license and filed
16 a bond as required by this chapter.

17 [Sec. 6]

18 (b) . . . No such attorney's title insurance
19 company shall permit any title attorney appointed by
20 it to write, sign, or deliver title insurance policies
21 within the state until the foregoing conditions have
22 been complied with, and the board has granted said
23 license. . . .

24 Revisor's Note

25 Section 5, V.T.I.C. Article 9.56, provides that
26 an attorney's title insurance company may not permit an
27 attorney to act as its title attorney unless the
28 attorney has "filed a bond as required by this chapter"
29 (V.T.I.C. Chapter 9). The revised law adds a reference
30 to other deposits permitted as an alternative to a bond
31 required by V.T.I.C. Chapter 9, revised in relevant
32 part as Section 2552.154, to provide clarity and for
33 the convenience of the reader.

34 Revised Law

35 Sec. 2552.202. LIST OF TITLE ATTORNEYS. (a) An
36 attorney's title insurance company shall certify to the department
37 the name and address of each title attorney appointed by the
38 attorney's title insurance company.

39 (b) The certification required by this section must:

- 1 (1) be on a form provided by the department; and
2 (2) be made on or before June 1 of each year unless a
3 system of staggered renewal is adopted under Section 4003.002.
4 (V.T.I.C. Art. 9.56, Sec. 6(b) (part).)

5 Source Law

6 (b) Unless a system of staggered renewal is
7 adopted under Article 21.01-2 of this code and its
8 subsequent amendments, on or before the first day of
9 June of each year, every attorney's title insurance
10 company operating under the provisions of this Chapter
11 9 shall certify to the board, on forms provided by the
12 board, the names and addresses of every title attorney
13 of said attorney's title insurance company, and
14

15 Revised Law

16 Sec. 2552.203. RENEWAL. An attorney's title insurance
17 company shall apply for license renewal and pay a fee prescribed by
18 the department in an amount not to exceed \$50 for each title
19 attorney listed under Section 2552.202. (V.T.I.C. Art. 9.56, Sec.
20 6(b) (part).)

21 Source Law

22 (b) . . . [every attorney's title insurance
23 company operating under the provisions of this Chapter
24 9 shall certify to the board, on forms provided by the
25 board, the names and addresses of every title attorney
26 of said attorney's title insurance company, and] shall
27 apply for and pay a fee in an amount not to exceed \$50
28 as determined by the board for an annual license in the
29 name of each title attorney included in said list;
30

31 Revisor's Note

32 Section 6(b), V.T.I.C. Article 9.56, refers to an
33 "annual license." The revised law adds a reference to
34 "license renewal" because it is clear from the context
35 that the license is renewed annually and the term is
36 consistent with usage in other licensing statutes.

37 Revised Law

38 Sec. 2552.204. NOTICE OF TERMINATION. An attorney's title
39 insurance company that terminates the appointment of a title
40 attorney shall:

- 41 (1) immediately notify the department in writing of
42 the termination and request cancellation of the title attorney's

1 license; and

2 (2) notify the title attorney of the action by the
3 attorney's title insurance company. (V.T.I.C. Art. 9.56, Sec. 6(b)
4 (part).)

5 Source Law

6 (b) . . . if any such attorney's title
7 insurance company shall terminate any licensed title
8 attorney, it shall immediately notify the board in
9 writing of such act and request cancellation of such
10 license, notifying the title attorney of such
11 action. . . .

12 [Sections 2552.205-2552.250 reserved for expansion]

13 SUBCHAPTER F. AUDIT AND EXAMINATION REQUIREMENTS RELATING TO TRUST

14 FUND ACCOUNTS

15 Revised Law

16 Sec. 2552.251. ANNUAL AUDIT. (a) A title attorney shall
17 have an annual audit made of trust fund accounts. The title
18 attorney shall pay for the audit.

19 (b) The audit must be performed by an independent certified
20 public accountant or licensed public accountant, or a firm composed
21 of either, recommended by the title attorney and approved by the
22 attorney's title insurance company represented by the title
23 attorney.

24 (c) The audit must include disclosure of payments made for
25 title evidence under a contract under Section 2552.153 and to whom
26 the payments were made.

27 (d) Not later than the 90th day after January 1 of each year,
28 the title attorney shall send by certified mail, postage prepaid,
29 to the department one copy of the audit report with a transmittal
30 letter. The title attorney shall also send a copy of the audit
31 report and transmittal letter to the attorney's title insurance
32 company represented by the title attorney. (V.T.I.C. Art. 9.56,
33 Secs. 7(d), 10 (part).)

34 Source Law

35 [Sec. 7]

36 (d) Each annual audit of each title attorney
37 shall include therein disclosure of the payments for
38 title information and to whom such payments were made.

1 an audit report from any of its title attorneys within
2 the time specified above, it shall forthwith report
3 such omission to the board.

4 All such reports and analyses furnished by the
5 attorney's title insurance company to the board shall,
6 at the election of the commissioner, be classed as
7 confidential and privileged after having been filed
8 with the board.
9 . . .

10 Revised Law

11 Sec. 2552.253. EXAMINATION OF TRUST FUND ACCOUNTS;
12 TRANSACTION REPORTS. (a) An attorney's title insurance company,
13 through its examiners or auditors or through independent certified
14 public accountants commissioned by the attorney's title insurance
15 company, may examine at any time the trust fund accounts and records
16 relating to the accounts of any of its title attorneys.

17 (b) The attorney's title insurance company shall pay for the
18 examination of the accounts and records.

19 (c) An attorney's title insurance company may require from
20 any of its title attorneys special reports regarding any of their
21 transactions. (V.T.I.C. Art. 9.56, Sec. 11.)

22 Source Law

23 Sec. 11. Any attorney's title insurance company
24 may at such time or times as it sees fit, through its
25 examiners or auditors or through independent certified
26 public accountants commissioned by it, examine the
27 trust fund accounts and records pertaining thereto of
28 any of its title attorneys, such examination to be made
29 at the expense of the attorney's title insurance
30 company; or the attorney's title insurance company may
31 require special reports from any such title attorney
32 regarding any of its transactions.

33 Revised Law

34 Sec. 2552.254. ENFORCEMENT; HEARING. (a) After notice
35 and hearing, the department may revoke the license of a title
36 attorney who:

37 (1) fails to furnish an annual audit report within the
38 time required by Section 2552.251; or

39 (2) furnishes an audit report that reveals any
40 irregularity, including a shortage, or any practice not in keeping
41 with sound, honest business practices.

42 (b) The notice must be provided to the title attorney and
43 the attorney's title insurance company represented by the title

1 attorney.

2 (c) At a hearing under this section, the title attorney and
3 the attorney's title insurance company may offer evidence
4 explaining or excusing a failure or irregularity. (V.T.I.C.
5 Art. 9.56, Sec. 10 (part).)

6 Source Law

7 Sec. 10. . . .

8 If any title attorney shall fail or refuse to
9 furnish an audit report within the time required, or
10 shall furnish an audit report which reveals any
11 shortage or other irregularity, or any practice not in
12 keeping with sound, honest business practices, the
13 board may, after notice to the title attorney and the
14 attorney's title insurance company involved and after
15 a hearing at which the attorney and attorney's title
16 insurance company may offer evidence explaining or
17 excusing such omissions or irregularity, revoke the
18 license of such title attorney.

19 . . .

20 Revisor's Note

21 Section 10, V.T.I.C. Article 9.56, allows an
22 appeal of any action taken by the board (now the
23 department of insurance and the commissioner of
24 insurance) under that article to be taken as provided
25 by Section 8 of that article, which authorizes an
26 appeal under V.T.I.C. Article 1.04, codified in 1999
27 as Subchapter D, Chapter 36, of this code. The revised
28 law omits the provision as redundant because an action
29 taken by the department or the commissioner under
30 Article 9.56 is already subject to appeal in the manner
31 provided by Subchapter D, Chapter 36, and an
32 additional statement to that effect in this chapter is
33 unnecessary. The omitted law reads:

34 Sec. 10. . . .

35 Any title attorney or attorney's title
36 insurance company feeling aggrieved by any
37 action of the board hereunder shall have the
38 right to file a suit in a District Court of
39 Travis County in the time and manner
40 provided in Section 8.

41 [Sections 2552.255-2552.300 reserved for expansion]

1 SUBCHAPTER G. LICENSE DENIAL AND DISCIPLINARY ACTION

2 Revised Law

3 Sec. 2552.301. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY
4 ACTION. The department may deny an application for a title
5 attorney's license or discipline a title attorney under Sections
6 4005.102, 4005.103, and 4005.104 if the department determines that
7 the applicant or license holder:

8 (1) has wilfully violated this title;

9 (2) has intentionally made a material misstatement in
10 the license application;

11 (3) has obtained or attempted to obtain the license by
12 fraud or misrepresentation;

13 (4) has misappropriated or converted to the
14 applicant's or license holder's own use or illegally withheld money
15 belonging to an attorney's title insurance company, an insured, or
16 another person;

17 (5) has been guilty of fraudulent or dishonest
18 practices;

19 (6) has materially misrepresented the terms and
20 conditions of a title insurance policy or contract;

21 (7) has failed to maintain:

22 (A) a separate and distinct accounting of escrow
23 funds; and

24 (B) an escrow bank account or accounts separate
25 and apart from all other accounts;

26 (8) is no longer a member of the State Bar of Texas; or

27 (9) is no longer actively engaged in the practice of
28 law. (V.T.I.C. Art. 9.56, Sec. 8(b).)

29 Source Law

30 (b) The department may discipline a title
31 attorney or deny an application under Section 5,
32 Article 21.01-2, of this code and its subsequent
33 amendments if it finds that the applicant for or holder
34 of such license:

35 (1) has wilfully violated any provision of
36 this Chapter 9;

37 (2) has intentionally made a material
38 misstatement in the application for such license;

1 (3) has obtained, or attempted to obtain,
2 such license by fraud or misrepresentation;

3 (4) has misappropriated or converted to
4 his own use or illegally withheld money belonging to an
5 attorney's title insurance company, an insured, or any
6 other person;

7 (5) has been guilty of fraudulent or
8 dishonest practices;

9 (6) has materially misrepresented the
10 terms and conditions of title insurance policies or
11 contracts;

12 (7) has failed to maintain a separate and
13 distinct accounting of escrow funds, and has failed to
14 maintain an escrow bank account or accounts separate
15 and apart from all other accounts;

16 (8) has failed to remain a member of the
17 State Bar of Texas, or has been disbarred; or

18 (9) is no longer actively engaged in the
19 practice of law.

20 Revisor's Note

21 Section 8(b), V.T.I.C. Article 9.56, authorizes
22 the department to discipline a title attorney or deny
23 an application "under Section 5, Article 21.01-2, of
24 this code and its subsequent amendments." Chapter
25 703, Acts of the 77th Legislature, Regular Session,
26 2001, redesignated Section 5, Article 21.01-2 as
27 Section 3A, Article 21.01-2, and amended the section
28 to provide that Subsections (c)-(f) of the section do
29 not apply to a person who is licensed or holds a
30 certificate of authority under V.T.I.C. Chapter 9,
31 revised as this title. Accordingly, the revised law
32 refers to Subsections (a) and (b) of Section 3A,
33 Article 21.01-2, revised as Sections 4005.102,
34 4005.103, and 4005.104. The revised law omits the
35 reference to "its subsequent amendments" for the
36 reason stated in Revisor's Note (1) to Section
37 2552.105.

38 Revised Law

39 Sec. 2552.302. LICENSE APPLICATION AFTER DENIAL, REFUSAL,
40 OR REVOCATION. (a) An applicant whose license application has
41 been denied or refused or a license holder whose license has been
42 revoked under this subchapter may not file another application for
43 a title attorney's license before the first anniversary of:

1 (1) the effective date of the denial, refusal, or
2 revocation; or

3 (2) the date of a final court order affirming the
4 denial, refusal, or revocation if judicial review is sought.

5 (b) A license application filed after the time required by
6 this section may be denied by the department unless the applicant
7 shows good cause why the denial, refusal, or revocation should not
8 be a bar to the issuance of a license. (V.T.I.C. Art. 9.56, Sec.
9 8(d).)

10 Source Law

11 (d) No applicant or licensee whose license has
12 been denied, refused, or revoked hereunder shall be
13 entitled to file another application for a license as a
14 title attorney within one year from the effective date
15 of such denial, refusal, or revocation, or, if
16 judicial review of such denial, refusal, or revocation
17 is sought, within one year from the date of final court
18 order or decree affirming such action. Such
19 application, when filed after one year, may be refused
20 by the board unless the applicant shows good cause why
21 the denial, refusal, or revocation of his license
22 shall not be deemed a bar to the issuance of a new
23 license.

24 Revisor's Note

25 Section 8(d), V.T.I.C. Article 9.56, refers to a
26 "court order or decree." The revised law omits the
27 reference to "decree" because, in context, "court
28 order" and "decree" have the same meaning and the
29 former term is more commonly used.

30 Revisor's Note
31 (End of Subchapter)

32 Section 8(e), V.T.I.C. Article 9.56, allows an
33 appeal of a disciplinary action or denial of an
34 application under that article to be taken under
35 V.T.I.C. Article 1.04, codified in 1999 as Subchapter
36 D, Chapter 36, of this code. The revised law omits the
37 provision as redundant because under V.T.I.C. Article
38 9.47, revised as Section 2551.001 of this code, a
39 disciplinary action or denial of an application under
40 Article 9.56 is already subject to appeal in the manner

1 provided by Subchapter D, Chapter 36, and an
2 additional statement to that effect in this chapter is
3 unnecessary. The omitted law reads:

4 (e) A disciplinary action or denial
5 of an application under this article may be
6 appealed under Article 1.04 of this code and
7 its subsequent amendments.

8 CHAPTER 2553. FOREIGN OR ALIEN CORPORATIONS

9 Sec. 2553.001. AUTHORITY TO ENGAGE IN BUSINESS OF TITLE

10 INSURANCE 1511

11 Sec. 2553.002. CAPITAL AND SURPLUS REQUIREMENTS 1512

12 Sec. 2553.003. TAXES AND FEES 1513

13 CHAPTER 2553. FOREIGN OR ALIEN CORPORATIONS

14 Revised Law

15 Sec. 2553.001. AUTHORITY TO ENGAGE IN BUSINESS OF TITLE
16 INSURANCE. (a) A corporation organized under the laws of another
17 state may engage in the business of title insurance in this state on
18 exactly the same basis and is subject to the same rules, prices, and
19 supervision as provided for a corporation that is organized under
20 the laws of this state and engaged in the business of title
21 insurance under this title.

22 (b) To engage in the business of title insurance in this
23 state, a foreign corporation must file with the department:

24 (1) an application for a permit or certificate of
25 authority; and

26 (2) a financial statement demonstrating the condition
27 of the corporation.

28 (c) The department shall prescribe the form of the
29 application and financial statement. (V.T.I.C. Arts. 9.10, 9.24.)

30 Source Law

31 Art. 9.10. Corporations organized under the
32 laws of any other state shall be permitted to do
33 business in this state on exactly the same basis and
34 subject to the same rules, regulations and prices and
35 supervision as fixed for Texas corporations doing
36 business under this Act.

37 Art. 9.24. Any foreign corporations desiring to
38 transact the character of business provided for in
39 this Act in this state shall make an application for

1 permit or certificate of authority to the Board in such
2 form as the Board shall prescribe and shall submit a
3 financial statement showing its condition in such form
4 as the Board shall prescribe.

5 Revisor's Note

6 (1) V.T.I.C. Article 9.10 refers to "Texas
7 corporations doing business under this Act." V.T.I.C.
8 Article 9.24 refers to foreign corporations "desiring
9 to transact the character of business provided for in
10 this Act." V.T.I.C. Articles 9.10 and 9.24 are
11 provisions of the Texas Title Insurance Act, which was
12 enacted by Chapter 219, Acts of the 60th Legislature,
13 Regular Session, 1967. The revised law substitutes
14 "title insurance" for "business under this Act" and
15 "character of business provided for in this Act"
16 because that is the only kind of business referred to
17 in the Texas Title Insurance Act.

18 (2) V.T.I.C. Article 9.10 refers to "rules,
19 regulations and prices and supervision." The
20 reference to "regulations" is omitted from the revised
21 law because under Section 311.005(5), Government Code
22 (Code Construction Act), a rule is defined to include a
23 regulation. That definition applies to the revised
24 law.

25 (3) V.T.I.C. Article 9.24 refers to the "Board"
26 meaning the "State Board of Insurance." Chapter 685,
27 Acts of the 73rd Legislature, Regular Session, 1993,
28 abolished the board and transferred its functions to
29 the commissioner of insurance and the Texas Department
30 of Insurance. Throughout this chapter, references to
31 the board have been changed to "commissioner" or
32 "department" as appropriate.

33 Revised Law

34 Sec. 2553.002. CAPITAL AND SURPLUS REQUIREMENTS. (a) A
35 foreign corporation may not engage in the business of title
36 insurance in this state unless the corporation has unimpaired

1 capital in an amount of at least \$1 million and a surplus in an
2 amount of at least \$1 million.

3 (b) The foreign corporation must demonstrate the required
4 capital and surplus from its financial statement and any other
5 examination the department may want to conduct. (V.T.I.C.
6 Art. 9.25.)

7 Source Law

8 Art. 9.25. No foreign corporation shall conduct
9 the business of title insurance in this state unless it
10 shall show from its financial statement and such other
11 examination as the Board may desire to make, an
12 unimpaired capital of not less than One Million
13 Dollars (\$1,000,000.00) and surplus of not less than
14 One Million Dollars (\$1,000,000.00).

15 Revised Law

16 Sec. 2553.003. TAXES AND FEES. (a) A corporation
17 organized and incorporated under the laws of another state,
18 territory, or country for the purpose of engaging in the business of
19 title insurance shall pay the same filing fees and occupation tax as
20 a foreign casualty company is required to pay to obtain a permit to
21 engage in the business of insurance in this state.

22 (b) A foreign title insurance company described by
23 Subsection (a) is not required to pay a franchise tax. (V.T.I.C.
24 Art. 9.31.)

25 Source Law

26 Art. 9.31. Any corporation organized and
27 incorporated under the laws of any other state,
28 territory or country for the purpose of transacting a
29 title insurance or title guaranty business shall be
30 required to pay the same filing fees and occupation tax
31 as any foreign casualty company is required to pay in
32 order to procure a permit to do business in Texas.
33 Such foreign title companies will not be required to
34 pay a franchise tax.

35 Revisor's Note

36 V.T.I.C. Article 9.31 refers to filing fees and
37 occupation taxes required to be paid by certain
38 corporations engaging in a "title insurance or title
39 guaranty business." The revised law omits the
40 reference to "title guaranty" because under V.T.I.C.
41 Article 9.02, revised in relevant part as Section

1 2501.005 of this title, the business of title
2 insurance is defined to include title guaranty.

3 [Chapters 2554-2600 reserved for expansion]

4 SUBTITLE C. FINANCIAL SOLVENCY

5 CHAPTER 2601. SUPERVISION, LIQUIDATION, REHABILITATION,
6 REORGANIZATION, OR CONSERVATION OF
7 TITLE INSURANCE COMPANIES AND AGENTS

8 Sec. 2601.001. SUPERVISION, LIQUIDATION, REHABILITATION,
9 REORGANIZATION, OR CONSERVATION OF TITLE
10 INSURANCE COMPANIES AND AGENTS 1514

11 CHAPTER 2601. SUPERVISION, LIQUIDATION, REHABILITATION,
12 REORGANIZATION, OR CONSERVATION OF
13 TITLE INSURANCE COMPANIES AND AGENTS

14 Revised Law

15 Sec. 2601.001. SUPERVISION, LIQUIDATION, REHABILITATION,
16 REORGANIZATION, OR CONSERVATION OF TITLE INSURANCE COMPANIES AND
17 AGENTS. Each title insurance agent and title insurance company is
18 subject to Articles 21.28 and 21.28-A. (V.T.I.C. Art. 9.29.)

19 Source Law

20 Art. 9.29. Articles 21.28 and 21.28-A of this
21 code apply to title insurance companies, title
22 insurance agents, and other companies doing a title
23 insurance business in this state.

24 Revisor's Note

25 V.T.I.C. Article 9.29 states that V.T.I.C.
26 Articles 21.28 and 21.28-A apply to title insurance
27 companies, title insurance agents, and "other
28 companies doing a title insurance business in this
29 state." The revised law omits the quoted language
30 because it was impliedly repealed through amendment of
31 V.T.I.C. Article 9.09 by Section 16.04, Chapter 685,
32 Acts of the 73rd Legislature, Regular Session, 1993.
33 Before amendment by Chapter 685, Article 9.09
34 prohibited a company that transacts another kind of
35 insurance from also engaging in the business of title

1 insurance, but provided an exception from that
 2 monoline requirement for certain corporations.
 3 Chapter 685 deleted that exception, and, as a result,
 4 "other companies," meaning companies other than title
 5 insurance companies or title insurance agents, are no
 6 longer authorized to engage in the business of title
 7 insurance.

8 CHAPTER 2602. TEXAS TITLE INSURANCE GUARANTY ASSOCIATION

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25 [Sections 2602.013-2602.050 reserved for expansion]

26 SUBCHAPTER B. GOVERNANCE OF TEXAS TITLE INSURANCE
 27 GUARANTY ASSOCIATION

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12 [Sections 2602.211-2602.250 reserved for expansion]

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21 [Sections 2602.356-2602.400 reserved for expansion]

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27 Sec. 2602.403. ASSETS ATTRIBUTABLE TO COVERED POLICIES . . . 1593

28 CHAPTER 2602. TEXAS TITLE INSURANCE GUARANTY ASSOCIATION

29 SUBCHAPTER A. GENERAL PROVISIONS

30 Revised Law

31 Sec. 2602.001. SHORT TITLE. This chapter may be cited as

32 the Texas Title Insurance Guaranty Act. (V.T.I.C. Art. 9.48, Sec.

33 1.)

1 substantive provisions revised elsewhere in this
2 chapter.

3 Revised Law

4 Sec. 2602.003. DEFINITIONS. In this chapter:

5 (1) "Affiliate" means a person who, directly or
6 indirectly, through one or more intermediaries, controls, is
7 controlled by, or is under common control with an impaired title
8 insurance company on December 31 of the year preceding the date the
9 company becomes impaired.

10 (2) "Agent" includes:

11 (A) a title insurance agent, as defined by
12 Section 2501.003;

13 (B) a title attorney, as defined by Section
14 2552.002; and

15 (C) a direct operation or a title insurance
16 company's wholly owned subsidiary or affiliate that performs the
17 services usually and customarily performed by a title insurance
18 agent.

19 (3) "Association" means the Texas Title Insurance
20 Guaranty Association.

21 (4) "Board" means the board of directors of the
22 association.

23 (5) "Impaired agent" means an agent that is:

24 (A) placed in:

25 (i) temporary or permanent receivership
26 under a court order based on a finding of insolvency; or

27 (ii) conservatorship after the
28 commissioner determines that the agent is insolvent; and

29 (B) designated by the commissioner as an impaired
30 agent.

31 (6) "Impaired title insurance company" means a title
32 insurance company that is:

33 (A) placed in:

34 (i) temporary or permanent receivership

1 under a court order based on a finding of insolvency; or

2 (ii) conservatorship after the
3 commissioner determines that the company is insolvent; and

4 (B) designated by the commissioner as an impaired
5 title insurance company.

6 (7) "Net direct written premiums" means the gross
7 amount of premiums paid by policyholders for issuance of title
8 insurance policies insuring risks located in this state and to
9 which this chapter applies, without deduction for premiums for
10 reinsurance ceded to other title insurance companies and not
11 including premiums for reinsurance accepted from other authorized
12 title insurance companies.

13 (8) "Payment of covered claims" means:

14 (A) the actual payment of claims; or

15 (B) the use of money of the impaired title
16 insurance company and money derived from assessments or guaranty
17 fees for consummation of contracts of reinsurance or assumption of
18 liabilities or contracts of substitution to provide for liabilities
19 arising from covered claims.

20 (9) "Trust funds or escrow accounts" includes accounts
21 subject to annual audit under Subchapter D, Chapter 2651.

22 (10) "Unauthorized insurer" means a person, firm,
23 association, or corporation that has engaged in activities
24 prohibited by Subchapter C, Chapter 101, while engaging in the
25 business of title insurance. (V.T.I.C. Art. 9.48, Secs. 5(4), (5),
26 (6), (7), (8), (9), (11), (12), (13), (14).)

27 Source Law

28 Sec. 5. As used in this article:

29 (4) "Impaired insurer" is (a) an insurer
30 which, after the effective date of this article, is
31 placed in temporary or permanent receivership under an
32 order of a court of competent jurisdiction based on a
33 finding of insolvency, and which has been designated
34 an "impaired insurer" by the commissioner; or (b)
35 after the effective date of this article, an insurer
36 placed in conservatorship after it has been deemed by
37 the commissioner to be insolvent and which has been
38 designated an "impaired insurer" by the commissioner.

39 (5) "Payment of covered claims" is actual

1 payment of claims and also is the utilization of funds
2 of the impaired insurer and funds derived from
3 assessments or from guaranty fees as provided by
4 Section 6 of this article for consummation of
5 contracts of reinsurance or assumption of liabilities
6 or contracts of substitution to provide for
7 liabilities arising from covered claims.

8 (6) "Net direct written premiums" is the
9 gross amount of premiums paid by policyholders for
10 issuance of policies of title insurance insuring risks
11 located in this state and to which this article
12 applies. The term does not include premiums for
13 reinsurance accepted from other licensed insurers, and
14 there shall be no deductions for premiums for
15 reinsurance ceded to other insurers.

16 (7) "Agent" includes a title insurance
17 agent as defined by Article 9.02(f) of this code, a
18 title attorney as defined by Section 2(d), Article
19 9.56 of this code, and any insurer's direct operation,
20 wholly owned subsidiary, or affiliate which performs
21 the services usually and customarily performed by a
22 title insurance agent.

23 (8) "Impaired agent" is:

24 (A) an agent that is placed in
25 temporary or permanent receivership under an order of
26 a court of competent jurisdiction based on a finding of
27 insolvency, and that has been designated an "impaired
28 agent" by the commissioner; or

29 (B) an agent placed in
30 conservatorship after it has been deemed by the
31 commissioner to be insolvent and that has been
32 designated an "impaired agent" by the commissioner.

33 (9) "Association" means the Texas Title
34 Insurance Guaranty Association.

35 (11) "Board" means the board of directors
36 of the association.

37 (12) "Unauthorized insurer" means a
38 person, firm, association, or corporation that has
39 engaged in activities prohibited by Section 3, Article
40 1.14-1 of this code while doing a title insurance
41 business.

42 (13) "Trust funds" or "escrow account"
43 includes those accounts which are subject to annual
44 audit pursuant to Article 9.39 of this code.

45 (14) "Affiliate" means a person who
46 directly or indirectly, through one or more
47 intermediaries, controls, is controlled by, or is
48 under common control with an impaired insurer on
49 December 31 of the year next proceeding the date the
50 insurer becomes an impaired insurer.

51 Revisor's Note

52 (1) Section 5(1), V.T.I.C. Article 9.48,
53 defines "State Board of Insurance" and "Commissioner."
54 The revised law omits those definitions as
55 unnecessary. Chapter 685, Acts of the 73rd
56 Legislature, Regular Session, 1993, abolished the
57 State Board of Insurance and transferred that board's
58 functions to the commissioner of insurance and the

1 Texas Department of Insurance. Throughout this
2 chapter, references to the board have been changed
3 appropriately. Definitions of "commissioner" and
4 "department" are unnecessary because Section 31.001 of
5 this code contains definitions of those terms that
6 apply to this title as a result of V.T.I.C. Article
7 9.47, revised as Section 2551.001 of this code. The
8 omitted law reads:

9 (1) A. "State Board of
10 Insurance" is the State Board of Insurance
11 of this State.

12 B. "Commissioner" is the
13 Commissioner of Insurance of this State.

14 (2) Section 5(3), V.T.I.C. Article 9.48,
15 defines "insurer" and Section 5(4), V.T.I.C. Article
16 9.48, defines "impaired insurer." The revised law
17 substitutes "title insurance company" and "impaired
18 title insurance company" for "insurer" and "impaired
19 insurer" for consistency with the terminology used in
20 this title. In addition, the revised law omits the
21 definition of "insurer" as unnecessary because it is
22 substantively identical to the definition of "title
23 insurance company" provided by Section (c), V.T.I.C.
24 Article 9.02, revised as Section 2501.003 of this code
25 and applicable to this chapter. The omitted law reads:

26 (3) "Insurer" is any title
27 insurance company authorized to do business
28 in this state, and doing business under and
29 regulated by the provisions of this Chapter
30 9.

31 (3) Section 5(4), V.T.I.C. Article 9.48, refers
32 to a title insurance company placed in receivership or
33 conservatorship "after the effective date of this
34 article." The article to which this language refers
35 was enacted by Chapter 409, Acts of the 64th
36 Legislature, Regular Session, 1975, which took effect
37 September 1, 1975. The revised law omits the quoted
38 language as unnecessary because any receivership or

1 conservatorship initiated before that date must have
2 concluded before the enactment of this revision.

3 (4) Sections 5(4) and (8), V.T.I.C. Article
4 9.48, refer to a court "of competent jurisdiction."
5 Throughout this chapter the revised law omits the
6 quoted language as unnecessary because the general
7 laws of civil jurisdiction determine which courts have
8 jurisdiction over the matter. For example, see
9 Sections 24.007-24.011, Government Code, for the
10 general jurisdiction of district courts.

11 (5) Section 5(6), V.T.I.C. Article 9.48, refers
12 to "licensed insurers." The revised law substitutes
13 "authorized" for "licensed" for consistency of
14 terminology in this code.

15 (6) Section 5(10), V.T.I.C. Article 9.48,
16 defines "account" to mean certain specific accounts
17 created under this chapter. The revised law omits this
18 definition as unnecessary because the revised law,
19 when referring to one of the specific accounts
20 included in the definition, uses the full name of the
21 account. The omitted law reads:

22 (10) "Account" means one of the
23 three accounts created under Section 14 of
24 this article.

25 (7) Section 5(14), V.T.I.C. Article 9.48,
26 refers to "the year next proceeding" a certain date.
27 The revised law substitutes "preceding" for
28 "proceeding" because the latter term makes no sense in
29 this context and is clearly a typographical error, and
30 omits "next" because "the year preceding" means "the
31 year next preceding."

32 Revised Law

33 Sec. 2602.004. DESCRIPTION OF CONTROL. (a) For purposes
34 of this chapter, control is the power to direct, or cause the
35 direction of, the management and policies of a person, other than

1 power that results from an official position with or corporate
2 office held by the person. The power may be possessed directly or
3 indirectly by any means, including through the ownership of voting
4 securities or by contract, other than a commercial contract for
5 goods or nonmanagement services.

6 (b) A person is presumed to control another person if the
7 person directly or indirectly owns, controls, holds with the power
8 to vote, or holds proxies representing 10 percent or more of the
9 voting securities of the other person. This presumption may be
10 rebutted by a showing that the person does not in fact control the
11 other person. (V.T.I.C. Art. 9.48, Sec. 5(15).)

12 Source Law

13 (15) "Control" means the possession,
14 direct or indirect, of the power to direct or cause the
15 direction of the management and policies of a person,
16 whether through the ownership of voting securities, by
17 contract other than a commercial contract for goods or
18 nonmanagement services, or otherwise, unless the power
19 is the result of an official position with or corporate
20 office held by the person. Control is presumed to
21 exist if any person, directly or indirectly, owns,
22 controls, holds with the power to vote, or holds
23 proxies representing 10 percent or more of the voting
24 securities of any other person. This presumption may
25 be rebutted by a showing that control does not exist in
26 fact.

27 Revised Law

28 Sec. 2602.005. APPLICABILITY; CONFLICT WITH OTHER
29 LAWS. (a) This chapter applies to:

30 (1) a title insurance company engaging in business
31 under this title;

32 (2) all title insurance, direct or reinsurance,
33 written by a title insurance company engaging in business under
34 this title; and

35 (3) trust funds or escrow accounts of:

36 (A) title insurance companies engaging in
37 business under this title; or

38 (B) agents authorized to engage in business in
39 this state and engaging in business under and governed by this
40 title.

1 (b) If this chapter conflicts with another law relating to
2 the subject matter of this chapter or its application, other than
3 Article 21.28 or 21.28-A, this chapter controls. If this chapter
4 conflicts with Article 21.28 or 21.28-A, that article controls.
5 (V.T.I.C. Art. 9.48, Secs. 3 (part), 21 (part).)

6 Source Law

7 Sec. 3. This article shall apply to all title
8 insurance (direct and reinsurance) written by title
9 insurance companies authorized to do business in this
10 state and doing business under and regulated by the
11 provisions of this Chapter 9 and to trust funds or
12 escrow accounts of title insurance companies or title
13 insurance agents authorized to do business in this
14 state and doing business under and regulated under
15 Chapter 9 of this code. . . .

16 Sec. 21. . . . in the event of conflict between
17 this article and other law relating to the subject
18 matter of this article or its application, the
19 provisions of this article shall control. However,
20 Articles 21.28 and 21.28-A of this code always prevail
21 over this article.

22 Revisor's Note

23 (1) Section 3, V.T.I.C. Article 9.48, refers to
24 a title insurance company "authorized to do business
25 in this state" and "regulated by the provisions of this
26 Chapter 9." The revised law omits the quoted language
27 and related references as unnecessary because those
28 phrases are incorporated into the definition of "title
29 insurance company" provided by V.T.I.C. Article 9.02,
30 revised as Section 2501.003 of this code, which
31 applies to the law revised in this chapter.

32 (2) Section 3, V.T.I.C. Article 9.48, refers to
33 "title insurance agents." Throughout this chapter the
34 revised law substitutes "agent" because the definition
35 of "agent" provided by Section 2602.003 includes a
36 "title insurance agent," and it is clear from the
37 context that the broader term applies.

38 (3) Section 21, V.T.I.C. Article 9.48, includes
39 a provision relating to the cumulative effect of that
40 article. The revised law omits this provision because

1 an accepted general principle of statutory
2 construction requires a statute to be given cumulative
3 effect with other statutes unless it provides
4 otherwise or unless the statutes are in conflict. The
5 general principle applies to this revision. The
6 omitted law reads:

7 Sec. 21. . . . This article is
8 cumulative of existing laws, but

9 Revised Law

10 Sec. 2602.006. CONSTRUCTION. (a) This chapter shall be
11 liberally construed to implement the purposes of this chapter
12 described by Section 2602.002, which shall be used to aid and guide
13 interpretation of this chapter.

14 (b) This chapter does not:

15 (1) expand or diminish a right or obligation between
16 or among policyholders, title insurance companies, or agents; or

17 (2) require a person to assign, waive, or relinquish a
18 claim, right, or cause of action arising under Chapter 541 of this
19 code or Subchapter E, Chapter 17, Business & Commerce Code.
20 (V.T.I.C. Art. 9.48, Secs. 3 (part), 4.)

21 Source Law

22 Sec. 3. . . . This article may not be deemed or
23 construed to expand or diminish any right or
24 obligation existing between or among policyholders,
25 title insurance companies, or title insurance agents
26 and may not be deemed or construed to require any
27 person to assign, waive, or relinquish any claim,
28 right, or cause of action arising under Article 21.21
29 of this code or under the Deceptive Trade
30 Practices-Consumer Protection Act (Section 17.41 et
31 seq., Business & Commerce Code).

32 Sec. 4. This article shall be liberally
33 construed to effect the purpose under Section 2 which
34 shall constitute an aid and guide to interpretation.

35 Revised Law

36 Sec. 2602.007. PROHIBITED USE OF PROTECTION PROVIDED BY
37 CHAPTER. (a) A title insurance company or agent may not advertise
38 or refer to this chapter as an inducement to the purchase of title
39 insurance.

40 (b) The use by a person of the protection provided by this

1 chapter in the sale of insurance is unfair competition and an unfair
2 practice under Chapter 541. (V.T.I.C. Art. 9.48, Secs. 16, 19(b).)

3 Source Law

4 Sec. 16. It shall be unlawful for an insurer or
5 agent to advertise or refer to this article in any
6 manner as an inducement to the purchase of title
7 insurance.

8 [Sec. 19]

9 (b) The use in any manner of the protection
10 afforded by this article by any person in the sale of
11 insurance shall constitute unfair competition and
12 unfair practices under Article 21.21 of this code and
13 that person is subject to that article.

14 Revisor's Note

15 Section 19(b), V.T.I.C. Article 9.48, provides
16 that certain unfair actions committed by a person are
17 governed by V.T.I.C. Article 21.21, revised as Chapter
18 541 of this code, and that "that person is subject to
19 that article." The revised law omits the quoted
20 language as unnecessary because it is clear that if an
21 action is governed by a law the person who committed
22 the action is subject to that law.

23 Revised Law

24 Sec. 2602.008. IMMUNITY. (a) Liability does not exist
25 and a cause of action does not arise against any of the following
26 persons for a good faith action or omission of the person in
27 exercising the person's powers and performing the person's duties
28 under this chapter:

29 (1) the commissioner or the commissioner's
30 representative;

31 (2) the association or the association's agent or
32 employee;

33 (3) a title insurance company or the company's agent or
34 employee;

35 (4) a board member; and

36 (5) a special deputy receiver or the special deputy
37 receiver's agent or employee.

38 (b) The attorney general shall defend any action to which

1 Subsection (a) applies that is brought against a person listed in
2 that subsection, including an action instituted after the
3 defendant's service with the association, commissioner, or
4 department has terminated. This subsection does not require the
5 attorney general to defend a person or entity with respect to an
6 issue other than the applicability or effect of the immunity
7 created by Subsection (a). The attorney general is not required to
8 defend a person listed in Subsection (a)(2), (3), (4), or (5)
9 against an action regarding the disposition of a claim filed with
10 the association under this chapter or any issue other than the
11 applicability or effect of the immunity created by Subsection (a).
12 The association may contract with the attorney general under
13 Chapter 771, Government Code, for legal services not covered by
14 this subsection.

15 (c) A title insurance company that reinsures or assumes the
16 policies of an impaired title insurance company is not liable, and a
17 cause of action does not arise against that company:

18 (1) for an action or omission by the impaired title
19 insurance company or an officer, director, employee, attorney, or
20 agent of the impaired title insurance company;

21 (2) by subrogation; or

22 (3) under any type of indemnity agreement. (V.T.I.C.
23 Art. 9.48, Secs. 10(i) (part), 17.)

24 Source Law

25 [Sec. 10]

26 (i) . . . There is no liability on the part of,
27 and no cause of action of any nature arises against,
28 any insurer that reinsures or assumes the policies of
29 an impaired insurer for any act or failure to act by
30 the impaired insurer or its officers, directors,
31 employees, attorneys, or agents or by subrogation or
32 under any type of indemnity agreement.

33 Sec. 17. (a) There shall be no liability on the
34 part of and no cause of action of any nature shall
35 arise against any member insurer of the association or
36 its agents or employees, the association or its agents
37 or employees, members of the association's board of
38 directors, the receiver, a special deputy receiver or
39 its agents or employees, or the commissioner or his
40 representatives for any good faith action or omission
41 in the performance of their powers and duties under
42 this article.

1 (b) The attorney general shall defend any action
2 to which Subsection (a) applies that is brought
3 against a member insurer or its agents or employees,
4 the association or its agents or employees, members of
5 the association's board of directors, a special deputy
6 receiver or its agents or employees, or the
7 commissioner or the commissioner's representatives.
8 This subsection continues to apply to an action
9 instituted after the defendant's service with the
10 guaranty association, commissioner, or department has
11 terminated. This subsection does not require the
12 attorney general to defend any person or entity with
13 respect to an issue other than the applicability or
14 effect of the immunity created by Subsection (a). The
15 attorney general is not required to defend any member
16 insurer of the association or its agents or employees,
17 the association or its agents or employees, members of
18 the association's board of directors, a special deputy
19 receiver or its agents or employees with respect to any
20 actions filed regarding the disposition of a claim
21 filed with the guaranty association under this Act or
22 to an issue other than the applicability or effect of
23 the immunity created by Subsection (a). The
24 association may contract with the attorney general
25 under the Interagency Cooperation Act (Article
26 4413(32), Vernon's Texas Civil Statutes) to provide
27 legal services not covered under this subsection.

28 Revisor's Note

29 (1) Section 10(i), V.T.I.C. Article 9.48,
30 limits the liability of certain persons for another
31 person's "act or failure to act." Section 17(a),
32 V.T.I.C. Article 9.48, limits the liability of certain
33 persons for their "action or omission." The quoted
34 phrases are synonymous, and for consistency the
35 revised law uses "action or omission" in both
36 instances.

37 (2) Section 17, V.T.I.C. Article 9.48, refers to
38 a "member insurer of the association" and to a "member
39 insurer." Throughout this chapter the revised law
40 omits references to title insurance companies being
41 members of the association because under Section
42 14(a), V.T.I.C. Article 9.48, revised in relevant part
43 as Section 2602.051, title insurance companies
44 described by this chapter must be members of the
45 association.

46 (3) Section 17(a), V.T.I.C. Article 9.48,
47 limits the liability of certain persons, including

1 "the receiver, a special deputy receiver . . . or the
2 commissioner." The revised law omits the reference to
3 "receiver" as unnecessary because under Section 2,
4 V.T.I.C. Article 21.28, applicable to this chapter as
5 described by Section 21, V.T.I.C. Article 9.48,
6 revised in relevant part as Section 2602.005, the
7 receiver will be either a special deputy receiver or
8 the commissioner.

9 (4) Section 17, V.T.I.C. Article 9.48, refers to
10 the Interagency Cooperation Act (Article 4413(32),
11 Vernon's Texas Civil Statutes). That act was codified
12 in 1991 as Chapter 771, Government Code. The revised
13 law is drafted accordingly.

14 Revised Law

15 Sec. 2602.009. ASSOCIATION AND TITLE INSURANCE COMPANIES AS
16 INTERESTED PARTIES. The association and each title insurance
17 company assessed under this chapter are interested parties under
18 Sections 3(h) and 12(b), Article 21.28. (V.T.I.C. Art. 9.48, Sec.
19 14(e)(8).)

20 Source Law

21 (8) The association or any insurer
22 assessed under this article shall be an interested
23 party under Sections 3(h) and 12(b) of Article 21.28 of
24 the Insurance Code.

25 Revised Law

26 Sec. 2602.010. RULES. The commissioner shall adopt
27 reasonable rules as necessary to implement and supplement this
28 chapter and its purposes. (V.T.I.C. Art. 9.48, Sec. 18.)

29 Source Law

30 Sec. 18. The State Board of Insurance is
31 authorized and directed to issue such reasonable rules
32 and regulations as may be necessary to carry out the
33 various purposes and provisions of this article and in
34 augmentation thereof.

35 Revisor's Note

36 Section 18, V.T.I.C. Article 9.48, refers to
37 "rules and regulations." The revised law omits the

1 reference to "regulations" because under Section
2 311.005(5), Government Code (Code Construction Act), a
3 rule is defined to include a regulation. That
4 definition applies to the revised law.

5 Revised Law

6 Sec. 2602.011. INFORMATION PROVIDED BY AND TO
7 COMMISSIONER. (a) The commissioner shall notify the association
8 of the existence of an impaired title insurance company not later
9 than the third day after the date on which the commissioner gives
10 notice of the designation of impairment. The association is
11 entitled to a copy of any complaint seeking an order of receivership
12 with a finding of insolvency against a title insurance company at
13 the time the complaint is filed with a court.

14 (b) The commissioner shall notify the board when the
15 commissioner receives a report from the commissioner of insurance
16 or other analogous officer of another state that indicates that a
17 title insurance company has been designated impaired in another
18 state. The report to the board must contain all significant details
19 of the action taken or the report received.

20 (c) The commissioner shall report to the board when the
21 commissioner has reasonable cause to believe from a completed or
22 continuing examination of any title insurance company that the
23 company may be an impaired title insurance company. The board may
24 use this information in performing its duties under this chapter.
25 The board shall keep the report and the information contained in the
26 report confidential until it is made public by the commissioner or
27 other lawful authority.

28 (d) On the board's request, the commissioner shall provide
29 the association with a statement of the net direct written premiums
30 of each title insurance company.

31 (e) The commissioner may require that the association
32 notify the insureds of the impaired title insurance company and any
33 other interested party of the designation of impairment and of the
34 person's rights under this chapter. Notification by publication in

1 a newspaper of general circulation is sufficient notice under this
2 section. (V.T.I.C. Art. 9.48, Sec. 15A.)

3 Source Law

4 Sec. 15A. (a) The commissioner shall notify
5 the association of the existence of an impaired
6 insurer not later than the third day after the date on
7 which the commissioner gives notice of the designation
8 of impairment. The association is entitled to a copy
9 of any complaint seeking an order of receivership with
10 a finding of insolvency against an insurer at the same
11 time that the complaint is filed with a court of
12 competent jurisdiction.

13 (b) The commissioner shall notify the board when
14 the commissioner receives a report from the
15 commissioner of insurance or other analogous officer
16 of another state that indicates that an insurer has
17 been designated impaired in another state. The report
18 to the board must contain all significant details of
19 the action taken or the report received from the other
20 commissioner or analogous officer.

21 (c) The commissioner shall report to the board
22 when the commissioner has reasonable cause to believe
23 from any examination, whether completed or in process,
24 of any insurer that the insurer may be an impaired
25 insurer. The board may use this information in
26 carrying out its duties and responsibilities under
27 this article. The board shall keep the report and the
28 information contained in the report confidential until
29 it is made public by the commissioner or other lawful
30 authority.

31 (d) On the request of the board, the
32 commissioner shall provide the association with a
33 statement of the net direct written premiums of each
34 insurer.

35 (e) The commissioner may require that the
36 association notify the insureds of the impaired
37 insurer and any other interested parties of the
38 designation of impairment and of their rights under
39 this article. Notification by publication in a
40 newspaper of general circulation is sufficient notice
41 under this section.

42 Revisor's Note

43 Section 15A(c), V.T.I.C. Article 9.48, refers to
44 the "duties and responsibilities" of the board of
45 directors. The revised law omits the reference to
46 "responsibilities" as unnecessary because
47 "responsibilities" is included within the meaning of
48 "duties."

49 Revised Law

50 Sec. 2602.012. APPEALS. (a) A title insurance company
51 may appeal to the commissioner an action or ruling of the
52 association relating to an assessment.

1 (b) An action or ruling of the commissioner under this
2 chapter may be appealed as provided by Subchapter D, Chapter 36.

3 (c) A title insurance company appealing an assessment shall
4 pay the assessment. The association may use the money to meet its
5 obligations while the appeal is pending. If the appeal on the
6 assessment is upheld, the association shall return to the company
7 the amount paid in error or excess.

8 (d) Venue in a suit relating to an action or ruling under
9 this chapter is in Travis County. Each party to the action may
10 appeal, and the appeal is at once returnable to the appellate court
11 and has precedence over all cases of a different character pending
12 before the court. The commissioner or association is not required
13 to give an appeal bond in an appeal of a cause of action arising
14 under this chapter. (V.T.I.C. Art. 9.48, Sec. 20.)

15 Source Law

16 Sec. 20. (a) A member insurer may appeal any
17 action or ruling of the association relating to an
18 assessment made under this article to the
19 commissioner.

20 (b) Any action or ruling of the commissioner
21 under this article may be appealed as provided in
22 Article 1.04 of the Insurance Code, as amended.

23 (c) If an insurer is appealing an assessment,
24 the amount assessed shall be paid to the association
25 and shall be available to meet association obligations
26 during the pendency of an appeal. If the appeal on the
27 assessment is upheld, the amount paid in error or
28 excess shall be returned to the insurer.

29 (d) Venue in a suit relating to any action or
30 ruling made under this article is in Travis County.
31 Either party to the action may appeal to the appellate
32 court having jurisdiction over the cause. The appeal
33 shall be at once returnable to the appellate court
34 having jurisdiction over the cause, and the action so
35 appealed shall have precedence in the appellate court
36 over all cases of a different character pending before
37 the court. The commissioner and association are not
38 required to give an appeal bond in an appeal of a cause
39 of action arising under this article.

40 Revisor's Note

41 (1) Section 20(b), V.T.I.C. Article 9.48,
42 refers to a provision of the Insurance Code, "as
43 amended." The revised law omits "as amended" as
44 unnecessary. Under Section 311.027, Government Code
45 (Code Construction Act), unless expressly provided

1 otherwise, a reference to a statute applies to all
2 reenactments, revisions, or amendments of the
3 statute. That provision applies to the revised law.

4 (2) Section 20(d), V.T.I.C Article 9.48, refers
5 to the appellate court "having jurisdiction over the
6 cause." The revised law omits the quoted language as
7 unnecessary for the reason stated in Revisor's Note (4)
8 to Section 2602.003.

9 [Sections 2602.013-2602.050 reserved for expansion]

10 SUBCHAPTER B. GOVERNANCE OF TEXAS TITLE

11 INSURANCE GUARANTY ASSOCIATION

12 Revised Law

13 Sec. 2602.051. ASSOCIATION AS LEGAL ENTITY; SUPERVISION;
14 MEMBERSHIP. (a) The Texas Title Insurance Guaranty Association
15 is a nonprofit legal entity.

16 (b) The association is subject to the applicable insurance
17 laws of this state and the immediate supervision of the
18 commissioner.

19 (c) A title insurance company may not engage in the business
20 of title insurance in this state unless the company is a member of
21 the association. (V.T.I.C. Art. 9.48, Sec. 14(a) (part).)

22 Source Law

23 Sec. 14. (a) Creation of the Association.
24 There is created a nonprofit legal entity to be known
25 as the "Texas Title Insurance Guaranty Association."
26 All insurers must be members of the association as a
27 condition precedent to their authority to transact
28 insurance in this state. . . .

29 The association is under the immediate
30 supervision of the commissioner and is subject to the
31 applicable insurance laws of this state.

32 Revisor's Note

33 Section 14(a), V.T.I.C. Article 9.48, states that
34 "[t]here is created a nonprofit legal entity to be
35 known as the 'Texas Title Insurance Guaranty
36 Association.'" The revised law omits the references to
37 "is created" and "to be known as" because that language
38 is executed.

1 Revised Law

2 Sec. 2602.052. BOARD OF DIRECTORS. (a) The association's
3 powers are exercised through a board of directors consisting of
4 nine individuals appointed by the commissioner.

5 (b) Three board members must be officers or employees of
6 title insurance companies. Two board members must be officers or
7 employees of agents. Four board members must be public
8 representatives.

9 (c) Board members other than public representatives shall
10 be chosen to give fair representation to all title insurance
11 companies and agents, considering the following categories:

12 (1) premium income;

13 (2) geographical location; and

14 (3) segments of the industry represented in this
15 state. (V.T.I.C. Art. 9.48, Secs. 14(a) (part), (b)(1) (part).)

16 Source Law

17 Sec. 14. (a) . . . The association . . .
18 shall exercise its powers through a board of
19 directors. . . .

20 (b) Board of directors. (1) The association
21 shall exercise its powers through a board of directors
22 consisting of nine persons, three of whom must be
23 employees or officers of the insurers, two of whom must
24 be employees or officers of the agents, and four of
25 whom must be public representatives as defined herein.
26 Board members, other than the public representatives,
27 shall be chosen to give fair representation to all
28 insurers and agents giving due consideration to the
29 various categories of premium income, geographical
30 location, and segments of the industry represented in
31 Texas. . . . Members of the board shall be appointed
32 by the State Board of Insurance

33 Revised Law

34 Sec. 2602.053. ELIGIBILITY TO SERVE AS PUBLIC
35 REPRESENTATIVE. (a) In this section, "immediate family" includes
36 parents, a spouse, children, brothers, and sisters residing in the
37 same household.

38 (b) To be eligible to serve as a public representative on
39 the board, an individual must have resided in this state during the
40 five years preceding appointment and may not be:

41 (1) licensed by or subject to the regulation of the

1 department;

2 (2) financially involved in an organization subject to
3 the regulation of the department other than by ownership of an
4 insurance policy or contract;

5 (3) a member of the immediate family of an individual
6 who is financially involved in an organization subject to the
7 regulation of the department;

8 (4) engaged in or employed by an entity having a
9 contract with an organization subject to the regulation of the
10 department;

11 (5) employed by, on the board of directors of, or a
12 holder of an elective office by or under the authority of a unit of
13 federal, state, or local government or an organization that
14 receives a significant part of its funding from a unit of federal,
15 state, or local government;

16 (6) employed by or associated with an organization
17 formed to represent license holders of the department or
18 organizations or individuals subject to the regulation of the
19 department; or

20 (7) required to register as a lobbyist under Chapter
21 305, Government Code, because of activities on behalf of an
22 organization representing the regulated industry. (V.T.I.C.
23 Art. 9.48, Sec. 14(b)(1) (part).)

24 Source Law

25 (1) . . . "Public representative" is an
26 individual who (i) has been a resident of Texas for at
27 least five years immediately preceding appointment,
28 (ii) is not licensed by the State Board of Insurance or
29 subject to the regulation of the State Board of
30 Insurance, (iii) is not financially involved in an
31 organization subject to the regulation of the State
32 Board of Insurance other than ownership of a policy or
33 contract of insurance, (iv) is not a member of the
34 immediate family of an individual who is financially
35 involved in an organization subject to the regulation
36 of the State Board of Insurance, (v) is not engaged in
37 or employed by an entity having a contract with an
38 organization subject to the regulation of the State
39 Board of Insurance, (vi) is not employed by, on the
40 board of directors of, or holding elective office by or
41 under the authority of any unit of federal, state, or
42 local government or any organization that receives a
43 significant part of its funding from any such unit of

1 federal, state, or local government, (vii) is not
2 employed by or associated with an organization formed
3 for the purpose of representing licensees of the State
4 Board of Insurance or organizations or individuals
5 subject to the regulation of the State Board of
6 Insurance, or (viii) is not required to register as a
7 lobbyist under Chapter 305, Government Code, by virtue
8 of activities on behalf of an association or other
9 organization representing the regulated industry.
10 "Immediate family" includes parents, spouse,
11 children, brothers, and sisters who reside in the same
12 household. . . .

13 Revisor's Note

14 (1) Section 14(b)(1)(i), V.T.I.C. Article 9.48,
15 refers to the "five years immediately preceding"
16 appointment of a board member. The revised law omits
17 "immediately" because "the five years preceding" means
18 "the five years immediately preceding."

19 (2) Section 14(b)(1)(viii), V.T.I.C. Article
20 9.48, refers to an "association or other
21 organization." The revised law omits the reference to
22 "association" because that term is included within the
23 meaning of "organization."

24 Revised Law

25 Sec. 2602.054. TERM; VACANCY. (a) Board members serve
26 staggered six-year terms, with the terms of three members expiring
27 each odd-numbered year. A member may serve more than one term.

28 (b) A member shall serve until a successor is appointed.

29 (c) If a member other than a public representative ceases to
30 be an officer or employee of a title insurance company or agent, the
31 member's office becomes vacant.

32 (d) The commissioner shall appoint an individual to fill a
33 vacancy on the board for the unexpired term. (V.T.I.C. Art. 9.48,
34 Sec. 14(b)(1) (part).)

35 Source Law

36 (1) . . . [Members of the board shall be
37 appointed] . . . to serve staggered six-year terms,
38 with the terms of three members expiring each
39 odd-numbered year. Each director shall serve until a
40 successor is appointed. A vacancy on the board shall
41 be filled for the unexpired term by the State Board of
42 Insurance. If any director, other than a public
43 representative, ceases to be an officer or employee of
44 a member insurer or an agent during a term of office,

1 the office is vacant. All directors are eligible to
2 serve more than one term.

3 Revised Law

4 Sec. 2602.055. COMPENSATION OF BOARD MEMBERS. A board
5 member may not receive compensation for the member's services but
6 is entitled to reimbursement for actual expenses incurred in
7 performing the member's duties. (V.T.I.C. Art. 9.48, Sec.
8 14(b)(2).)

9 Source Law

10 (2) Directors may not receive any
11 remuneration or emolument of office but are entitled
12 to reimbursement for their actual expenses incurred in
13 performing their duties as directors.

14 Revisor's Note

15 Section 14(b)(2), V.T.I.C. Article 9.48, refers
16 to a director's receipt of "remuneration or
17 emolument." The revised law substitutes
18 "compensation" for the quoted language for consistency
19 with the terminology used in this code and because
20 "compensation" is the more commonly used term.

21 Revised Law

22 Sec. 2602.056. FINANCIAL STATEMENT OF BOARD MEMBER. Each
23 board member shall file with the Texas Ethics Commission a
24 financial statement as provided by Subchapter B, Chapter 572,
25 Government Code. (V.T.I.C. Art. 9.48, Secs. 14(b)(3), (c) (part).)

26 Source Law

27 [(b)]

28 (3) Each director of the association shall
29 file a financial statement with the secretary of state
30 in accordance with Sections 3 and 4, Chapter 421, Acts
31 of the 63rd Legislature, Regular Session, 1973
32 (Article 6252-9b, Vernon's Texas Civil Statutes).

33 (c) . . .

34 (3) Each director of the association shall
35 file a financial statement with the Texas Ethics
36 Commission in accordance with Subchapter B, Chapter
37 572, Government Code.

38 . . .

39 Revisor's Note

40 Section 14(b)(3), V.T.I.C. Article 9.48,
41 requires each board member to file a financial
42 statement with the secretary of state as provided by

1 Sections 3 and 4, Chapter 421, Acts of the 63rd
2 Legislature, Regular Session, 1973 (Article 6252-9b,
3 Vernon's Texas Civil Statutes). Section 14(c)(3)
4 requires the member to file that report with the Texas
5 Ethics Commission as provided by Subchapter B, Chapter
6 572, Government Code. The duties of the secretary of
7 state under Article 6252-9b were transferred to the
8 Texas Ethics Commission in 1991, and Sections 3 and 4
9 of Article 6252-9b were codified in 1993 as Subchapter
10 B, Chapter 572, Government Code. The revised law is
11 drafted accordingly.

12 Revised Law

13 Sec. 2602.057. RIGHTS OF TITLE INSURANCE COMPANY WITH
14 REPRESENTATIVE ON BOARD. (a) A title insurance company is not
15 prohibited, because the company has an officer, director, or
16 employee serving as a board member, from negotiating for or
17 entering into a contract of reinsurance or assumption of liability
18 or a contract of substitution to provide for liabilities for
19 covered claims with the receiver or conservator of an impaired
20 title insurance company or agent.

21 (b) A conflict of interest does not arise from entering into
22 a contract described by this section. (V.T.I.C. Art. 9.48, Sec.
23 14(e)(7).)

24 Source Law

25 (7) Any insurer that has an officer,
26 director, or employee serving as a member of the board
27 shall not lose the right to negotiate for and enter
28 into contracts of reinsurance or assumption of
29 liability or contracts of substitution to provide for
30 liabilities for covered claims with the receiver or
31 conservator of an impaired insurer or agent. The
32 entering into any such contract shall not be deemed a
33 conflict of interest.

34 [Sections 2602.058-2602.100 reserved for expansion]

35 SUBCHAPTER C. GENERAL POWERS AND DUTIES OF ASSOCIATION

36 Revised Law

37 Sec. 2602.101. GENERAL POWERS AND DUTIES. (a) In
38 addition to the other powers and duties provided by this chapter,

1 the association may:

2 (1) borrow money as necessary to implement this
3 chapter according to the plan of operation;

4 (2) lend money to an impaired title insurance company;

5 (3) sue and be sued, including taking any legal action
6 necessary or proper to recover an unpaid assessment;

7 (4) enter into contracts as necessary or proper to
8 implement this chapter;

9 (5) ensure payment of the policy obligations of an
10 impaired title insurance company;

11 (6) negotiate and contract with a rehabilitator,
12 conservator, receiver, or ancillary receiver to exercise the powers
13 and perform the duties of the association;

14 (7) guarantee, assume, or reinsure, or cause to be
15 guaranteed, assumed, or reinsured, a policy or contract of an
16 impaired title insurance company;

17 (8) take legal action necessary to avoid the payment
18 of improper claims or to settle claims or potential claims against
19 an impaired title insurance company or the association; and

20 (9) perform any other acts as necessary or proper to
21 implement this chapter.

22 (b) The association has standing to appear before a court in
23 this state with jurisdiction over an impaired title insurance
24 company or agent concerning which the association is or may become
25 obligated under this chapter. (V.T.I.C. Art. 9.48, Sec. 14(c)
26 (part).)

27 Source Law

28 (c) Powers and duties of association. In
29 addition to the powers and duties provided by other
30 sections of this article, the association:

31 . . .
32 (2) has standing to appear before any
33 court in this state with jurisdiction over an impaired
34 insurer or agent concerning which the association is
35 or may become obligated under this article;

36 . . .
37 (4) may borrow funds as necessary to
38 implement this article in accordance with the plan of
39 operation;

40 (5) may lend money to an impaired insurer;

1 (6) sue or be sued, including taking any
2 legal actions necessary or proper for recovery of any
3 unpaid assessments;

4 (7) may enter into contracts as necessary
5 or proper to implement this article;

6
7 (9) may ensure payment of the policy
8 obligations of an impaired insurer;

9 (10) may negotiate and contract with any
10 liquidator, rehabilitator, conservator, receiver, or
11 ancillary receiver to carry out the powers and duties
12 of the association;

13 (11) may guarantee, assume, or reinsure,
14 or cause to be guaranteed, assumed, or reinsured, a
15 policy or contract of an impaired insurer;

16 (12) may take legal action as necessary to
17 avoid the payment of improper claims, or to settle
18 claims or potential claims against the impaired
19 insurer or association;

20
21 (15) may perform other acts as necessary
22 or proper to implement this article.

23 Revisor's Note

24 Section 14(c)(10), V.T.I.C. Article 9.48, allows
25 the association to negotiate and contract with a
26 "liquidator" and a "receiver." The revised law omits
27 the reference to "liquidator" because under Section
28 1(d), V.T.I.C. Article 21.28, applicable to this
29 chapter as described by Section 21, V.T.I.C. Article
30 9.48, revised in relevant part as Section 2602.005,
31 the terms are synonymous and the latter is the term
32 more commonly used in this chapter.

33 Revised Law

34 Sec. 2602.102. PLAN OF OPERATION. (a) The association
35 shall perform its functions under a plan of operation. The plan of
36 operation must contain provisions necessary or proper for the
37 execution of the association's powers and duties. The plan of
38 operation must, in addition to the other requirements of this
39 chapter:

40 (1) establish:

41 (A) procedures for handling the assets of the
42 association;

43 (B) the amount and method of reimbursing board
44 members;

45 (C) regular places and times for board meetings;

1 (D) procedures for maintaining records of all
2 financial transactions of the association, its agents, and the
3 board; and

4 (E) procedures for determining the amount of
5 guaranty fees, for collecting those fees, and for assessments; and

6 (2) contain additional provisions necessary or proper
7 for the execution of the association's powers and duties.

8 (b) The association shall submit to the commissioner any
9 amendment to the plan of operation necessary or suitable to ensure
10 the fair, reasonable, and equitable administration of the
11 association. The amendment takes effect on the commissioner's
12 written approval.

13 (c) If the association does not submit a suitable amendment
14 to the plan of operation, the commissioner after notice and hearing
15 may adopt reasonable rules as necessary or advisable to implement
16 this chapter. A rule continues in effect until modified by the
17 commissioner or superseded by an amendment submitted by the
18 association and approved by the commissioner.

19 (d) Each title insurance company shall comply with the plan
20 of operation. (V.T.I.C. Art. 9.48, Secs. 14(a) (part), (d)(1), (2)
21 (part), (3), (4).)

22 Source Law

23 Sec. 14. (a) . . . [The association] shall
24 perform its functions under the plan of operation and
25

26 (d) Plan of operation. (1) The association
27 shall submit to the commissioner a plan of operation
28 and any amendment to the plan of operation necessary or
29 suitable to assure the fair, reasonable, and equitable
30 administration of the association. The plan of
31 operation and any amendments to the plan of operation
32 are effective on approval in writing by the
33 commissioner.

34 (2) . . . if at any time after this
35 article takes effect the association fails to submit
36 suitable amendments to the plan, the commissioner,
37 after notice and hearing, may promulgate reasonable
38 rules as are necessary or advisable to carry out this
39 article. The rules shall continue in force until
40 modified by the commissioner or superseded by a plan
41 submitted by the association and approved by the
42 commissioner.

43 (3) All insurers shall comply with the
44 plan of operation.

1 (4) The plan of operation shall, in
2 addition to requirements provided in other parts of
3 this article:

4 A. establish procedures for handling
5 the assets of the association;

6 B. establish the amount and method of
7 reimbursing members of the board;

8 C. establish regular places and times
9 for meetings of the board of directors;

10 D. establish procedures for records
11 to be kept of all financial transactions of the
12 association, its agents, and the board of directors;

13 E. establish any additional
14 procedures for determining the amount of guaranty fees
15 and for collecting guaranty fees under Section 6 of
16 this article;

17 F. establish any additional
18 procedures for assessments under Section 7 of this
19 article; and

20 G. contain additional provisions
21 necessary or proper for the execution of the powers and
22 duties of the association.

23 Revisor's Note

24 Section 14(d), V.T.I.C. Article 9.48, requires
25 the association to submit a plan of operation within
26 180 days of the effective date of that article.
27 Section 14(d) was enacted by Section 1, Chapter 1073,
28 Acts of the 70th Legislature, Regular Session, 1987,
29 and took effect September 1, 1987. Because the period
30 for submission of the plan has expired, the revised law
31 omits the provision establishing the deadline for
32 submitting the original plan, omits related
33 references to this submission, and makes additional
34 conforming changes as necessary. The omitted law
35 reads:

36 (2) If the association fails to
37 submit a suitable plan of operation within
38 180 days following the effective date of
39 this article, or

40 Revised Law

41 Sec. 2602.103. EMPLOYEES AND EXPERTS. (a) The
42 association may employ or retain persons to perform the functions
43 necessary or proper under this chapter, including persons necessary
44 to handle the association's financial transactions.

45 (b) On the commissioner's request, the association shall
46 retain one or more persons to:

1 (1) audit and review agent escrow and trust accounts,
2 financial condition, and compliance with applicable statutes and
3 rules; and

4 (2) report to the commissioner on the accounts,
5 condition, and compliance.

6 (c) A person retained under Subsection (b) acts solely under
7 the direction of and as assigned by the commissioner.

8 (d) From the guaranty fee account, the association shall
9 compensate a person retained under Subsection (b) and reimburse the
10 person for the person's reasonable and necessary expenses.
11 (V.T.I.C. Art. 9.48, Sec. 14(c) (part).)

12 Source Law

13 (c) . . . [the association:]

14 . . .
15 (8) may employ or retain such persons who
16 are necessary to handle the financial transactions of
17 the association, and to perform any other functions
18 that become necessary or proper under this article;

19 . . .
20 (13) shall, on the request of the
21 commissioner, authorize the expenditure of funds from
22 the guaranty fee account to retain, compensate, and
23 reimburse for reasonable and necessary expenses, a
24 person or persons who will audit and review agent
25 escrow and trust accounts, financial condition, and
26 compliance with applicable statutes and rules and make
27 reports relating to the accounts, agent financial
28 condition, and compliance to the commissioner, solely
29 under the direction of and as assigned by the
30 commissioner;

31 . . .

32 Revised Law

33 Sec. 2602.104. ASSOCIATION RECORDS. (a) The association
34 shall maintain a record of each negotiation or meeting in which the
35 association or the association's representative discusses the
36 association's activities in exercising its powers and performing
37 its duties under this chapter.

38 (b) A record under Subsection (a) may be made public only
39 on:

40 (1) termination of a liquidation, rehabilitation, or
41 conservation proceeding involving the impaired or insolvent title
42 insurance company;

43 (2) termination of the impairment or insolvency of the

1 title insurance company; or

2 (3) order of a court.

3 (c) This section does not limit the association's duty to
4 report on its activities under this chapter. (V.T.I.C. Art. 9.48,
5 Sec. 23(a).)

6 Source Law

7 Sec. 23. (a) The association shall maintain
8 records of all negotiations and meetings in which the
9 association or its representatives discuss the
10 activities of the association in carrying out its
11 powers and duties under this article. Records of the
12 negotiations or meetings may be made public only on the
13 termination of a liquidation, rehabilitation, or
14 conservation proceeding involving the impaired or
15 insolvent insurer, on the termination of the
16 impairment or insolvency of the insurer, or on the
17 order of a court of competent jurisdiction. This
18 subsection does not limit the duty of the association
19 to report on its activities under Section 14 of this
20 article.

21 Revisor's Note

22 Section 23(a), V.T.I.C. Article 9.48, provides
23 that the section does not limit the association's duty
24 to report on its activities under Section 14 of that
25 article. The revised law refers to the association's
26 activities under Article 9.48, revised as this
27 chapter, rather than referring only to the law
28 revising Section 14. Section 14 enumerates the powers
29 and duties of the association. It is clear from the
30 context of Section 23(a) that the purpose of the
31 reference to Section 14 is to continue to require the
32 association to report on its powers and duties under
33 this chapter.

34 Revised Law

35 Sec. 2602.105. MEETING BY CONFERENCE CALL. Notwithstanding
36 Chapter 551, Government Code, the board may hold an open meeting by
37 telephone conference call if immediate action is required and
38 convening of a quorum of the board at a single location is not
39 reasonable or practical. The meeting is subject to the notice
40 requirements that apply to other meetings. The notice of the

1 meeting must specify as the location of the meeting the location at
2 which meetings of the board are usually held, and each part of the
3 meeting that is required to be open to the public must be audible to
4 the public at that location and must be tape-recorded. The tape
5 recording shall be made available to the public for 30 days after
6 the meeting date. (V.T.I.C. Art. 9.48, Sec. 14(g).)

7 Source Law

8 (g) Notwithstanding Chapter 271, Acts of the
9 60th Legislature, Regular Session, 1967 (Article
10 6252-17, Vernon's Texas Civil Statutes), the board may
11 hold an open meeting by telephone conference call if
12 immediate action is required and the convening at one
13 location of a quorum of the board is not reasonable or
14 practical. The meeting is subject to the notice
15 requirements applicable to other meetings. The notice
16 of the meeting must specify as the location of the
17 meeting the location at which meetings of the board are
18 usually held. Each part of the meeting that is
19 required to be open to the public shall be audible to
20 the public at the location specified in the notice of
21 the meeting as the location of the meeting and shall be
22 tape recorded. The tape recording shall be made
23 available to the public for 30 days after the meeting
24 date.

25 Revisor's Note

26 Section 14(g), V.T.I.C. Article 9.48, refers to
27 Chapter 271, Acts of the 60th Legislature, Regular
28 Session, 1967 (Article 6252-17, Vernon's Texas Civil
29 Statutes). That law was codified in 1993 as Chapter
30 551, Government Code. The revised law is drafted
31 accordingly.

32 Revised Law

33 Sec. 2602.106. ACCOUNTS. For purposes of administration
34 and assessment, the board shall establish:

- 35 (1) an administrative account;
- 36 (2) a title account; and
- 37 (3) a guaranty fee account. (V.T.I.C. Art. 9.48, Sec.
38 14(a) (part).)

39 Source Law

40 Sec. 14. (a) . . . For the purposes of
41 administration and assessment, the board shall
42 establish three accounts:
43 (1) the administrative account;
44 (2) the title account; and

1 (3) the guaranty fee account. . . .

2 Revised Law

3 Sec. 2602.107. ADMINISTRATIVE EXPENSES. (a) The
4 association may use money in the administrative account to pay
5 administrative costs and other general expenses of the association.

6 (b) The association may transfer income from investment of
7 the association's money to the administrative account.

8 (c) The association shall assess title insurance companies
9 as provided by Subchapter E for any additional money needed for the
10 administrative account. (V.T.I.C. Art. 9.48, Sec. 7(e).)

11 Source Law

12 (e) Income from the investment of any of the
13 funds of the association may be transferred to the
14 administrative account authorized in Section 14(a)(1)
15 of this article. The funds in this account may be used
16 by the association for the purpose of meeting
17 administrative costs and other general expenses of the
18 association. If additional funds are needed for the
19 administrative account, the association shall assess
20 insurers to attain the needed funds in the same manner
21 provided by this section.

22 Revised Law

23 Sec. 2602.108. DEPOSIT OF FEES AND ASSESSMENTS. The
24 association may deposit fees and assessments it collects into the
25 Texas Treasury Safekeeping Trust Company in accordance with
26 procedures established by the comptroller. The comptroller shall
27 account to the association for the deposited money separately from
28 all other money. (V.T.I.C. Art. 9.48, Sec. 6A.)

29 Source Law

30 Sec. 6A. All assessments and fees collected by
31 the association may be deposited into the Texas
32 Treasury Safekeeping Trust Company in accordance with
33 procedures established by the comptroller. The funds
34 deposited shall be accounted for separately from all
35 other funds by the comptroller to the association.

36 Revised Law

37 Sec. 2602.109. USE OF EXCESS MONEY IN ACCOUNTS. (a) If
38 the association determines that money in the title account exceeds
39 the amount reasonably necessary for efficient future operation
40 under this chapter, the association shall return the excess money
41 pro rata to the holders of participation receipts on which an

1 outstanding balance exists after deducting any credits against
2 premium taxes taken under Section 2602.210. The amount deducted
3 for those credits shall be deposited with the comptroller for
4 credit to the general revenue fund. The association shall transfer
5 to the guaranty fee account any excess money remaining in the title
6 account after the distribution.

7 (b) If the association determines that money in the
8 administrative account exceeds the amount reasonably necessary for
9 efficient future operation under this chapter, the association
10 shall transfer the excess money to the guaranty fee account.
11 (V.T.I.C. Art. 9.48, Secs. 9(b), (c).)

12 Source Law

13 (b) Should the association at any time determine
14 that money exists in the title account in excess of the
15 amount reasonably necessary for efficient future
16 operation under the terms of this article, it shall
17 cause the excess money to be returned pro rata to the
18 holders of any participation receipts on which there
19 is a balance outstanding after deducting any credits
20 taken against premium taxes as authorized by Section
21 15 of this article. The amount deducted for those
22 credits shall be deposited with the comptroller for
23 credit to the general fund of this state. Any excess
24 money remaining in the title account after the
25 distribution shall be transferred by the association
26 to the guaranty fee account to be used as provided by
27 this article.

28 (c) If the association determines at any time
29 that money exists in the administrative account in
30 excess of the amount reasonably necessary for
31 efficient future operation under the terms of this
32 article, the association shall transfer the excess
33 money to the guaranty fee account to be used as
34 provided by this article.

35 Revised Law

36 Sec. 2602.110. EXPENSES OF RECEIVERSHIP OR
37 CONSERVATORSHIP. The association may advance money necessary to
38 pay the expenses of administering the receivership or
39 conservatorship estate of an impaired title insurance company or
40 agent, on terms the association negotiates, if the company's or
41 agent's assets are insufficient to pay those expenses. (V.T.I.C.
42 Art. 9.48, Sec. 5(2)C (part).)

43 Source Law

44 C. If an impaired insurer or an
45 impaired agent has insufficient assets to pay the

1 expenses of administering the receivership or
2 conservatorship estate, the association may advance
3 funds necessary to pay those expenses on the terms it
4 may negotiate. . . .

5 Revised Law

6 Sec. 2602.111. DELEGATION OF POWERS AND DUTIES. (a) The
7 plan of operation may provide that, on approval of the board and the
8 commissioner, a power or duty of the association may be delegated to
9 a corporation or other organization that:

10 (1) performs or will perform in two or more states
11 functions similar to those of the association or its equivalent;
12 and

13 (2) provides protection not substantially less
14 favorable and effective than that provided by this chapter.

15 (b) A power or duty under Section 2602.101(a)(1) or (4),
16 2602.107, 2602.201, 2602.202, 2602.203, or 2602.205 may not be
17 delegated under this section.

18 (c) The corporation or other organization shall be:

19 (1) reimbursed as a servicing facility would be
20 reimbursed; and

21 (2) paid for its performance of any other functions of
22 the association. (V.T.I.C. Art. 9.48, Sec. 14(f).)

23 Source Law

24 (f) Delegation of powers and duties. The plan
25 of operation may provide that any or all powers and
26 duties of the association, except those under Sections
27 7 and 14(c)(3) of this article, may be delegated to a
28 corporation, association, or other organization that
29 performs or will perform functions similar to those of
30 the association or its equivalent in two or more
31 states. The corporation, association, or organization
32 shall be reimbursed as a servicing facility would be
33 reimbursed and shall be paid for its performance of any
34 other functions of the association. A delegation
35 under this subsection may take effect only with the
36 approval of both the board of directors and the
37 commissioner and may be made only to a corporation,
38 association, or organization that extends protection
39 not substantially less favorable and effective than
40 that provided by this article.

41 Revisor's Note

42 (1) Section 14(f), V.T.I.C. Article 9.48,
43 provides that the association's plan of operation may
44 delegate to a corporation, association, or other

1 organization "any or all powers and duties of the
2 association, except those under Sections 7 and
3 14(c)(3) of this article." Although parts of Section 7
4 are revised in this chapter as Sections 2602.151(d),
5 2602.204, 2602.208(c), and 2602.209(d), the revised
6 law omits the references to those sections because
7 they do not contain a power or duty of the association.

8 The revised law also corrects the reference to
9 Section 14(c)(3). Subsection (f) was added to Section
10 14, Article 9.48, by Section 1.15, Chapter 12, Acts of
11 the 72nd Legislature, 2nd Called Session, 1991. At
12 that time, Section 14(c)(3), Article 9.48, authorized
13 the association to "enter into such contracts that are
14 necessary or proper, including the power to borrow
15 money and to invest funds, and to carry out the
16 provisions and purposes of this article." Subsequent
17 amendments of Section 14(c) restructured Subsection
18 (c) so that, at the time of this revision, Subsection
19 (c)(3) addresses the duty of a board member of the
20 association to file personal financial statements,
21 while Subsections (c)(4) and (7) address the substance
22 previously contained in Subsection (c)(3),
23 specifically, as amended by Section 11.07, Chapter
24 685, Acts of the 73rd Legislature, Regular Session,
25 1993, Section 14(c)(4) authorizes the association to
26 "borrow funds as necessary to implement this article
27 in accordance with the plan of operation" and Section
28 14(c)(7) authorizes the association to "enter into
29 contracts as necessary or proper to implement this
30 article." The association is no longer explicitly
31 granted the power to invest its funds. Accordingly,
32 the revised law refers to Sections 2602.101(a)(1) and
33 (4), the revisions of, respectively, Sections 14(c)(4)
34 and (7).

1 (2) Section 14(f), V.T.I.C. Article 9.48,
2 refers to a "corporation, association, or [other]
3 organization." The revised law omits the reference to
4 "association" for the reason stated in Revisor's Note
5 (2) to Section 2602.053.

6 Revised Law

7 Sec. 2602.112. EXEMPTION FROM TAXATION. The association
8 is exempt from payment of all fees and all taxes levied by this
9 state or a subdivision of this state, except taxes levied on real or
10 personal property. (V.T.I.C. Art. 9.48, Sec. 20A.)

11 Source Law

12 Sec. 20A. The association is exempt from
13 payment of all fees and all taxes levied by this state
14 or any of its subdivisions except taxes levied on real
15 or personal property.

16 Revised Law

17 Sec. 2602.113. DETECTION AND PREVENTION OF IMPAIRMENT. (a)
18 The board may make recommendations to the commissioner for
19 detecting and preventing title insurance company or agent
20 impairments. The board shall advise and counsel with the
21 commissioner on matters relating to the solvency of title insurance
22 companies and agents.

23 (b) The board may report and make recommendations to the
24 commissioner relating to any matter germane to the solvency,
25 liquidation, rehabilitation, or conservation of a title insurance
26 company or agent. A report or recommendation under this subsection
27 is not a public document until a title insurance company is
28 designated impaired.

29 (c) The board shall notify the commissioner of any
30 information indicating that a title insurance company or agent may
31 be unable or potentially unable to fulfill its contractual
32 obligations and shall request a meeting with the commissioner. The
33 board may request appropriate investigation and action by the
34 commissioner. The commissioner may investigate and act as the
35 commissioner considers appropriate. (V.T.I.C. Art. 9.48, Secs.

1 14(e)(2), (3) (part), (4), (5).)

2 Source Law

3 (e) Prevention of impairments. . . .

4 (2) The board of directors shall notify
5 the commissioner of any information indicating any
6 insurer or agent may be unable or potentially unable to
7 fulfill its contractual obligations and may request
8 appropriate investigation and action by the
9 commissioner who may, in his discretion, make any
10 investigation and take any action as he deems
11 appropriate.

12 (3) The board shall advise and counsel
13 with the commissioner upon matters relating to the
14 solvency of insurers and agents. . . . The board shall
15 notify the commissioner of any information indicating
16 that an insurer or agent may be unable or potentially
17 unable to fulfill its contractual obligations and
18 request a meeting with the commissioner. . . .

19 (4) The board may make reports and
20 recommendations to the commissioner relating to any
21 matter germane to the solvency, liquidation,
22 rehabilitation, or conservation of any insurer or
23 agent. Those reports and recommendations shall not be
24 considered public documents until such time as an
25 insurer is declared to be impaired.

26 (5) The board may make recommendations to
27 the commissioner for the detection and prevention of
28 insurer or agent impairments.

29 Revisor's Note

30 Section 14(e)(1), V.T.I.C. Article 9.48,
31 provides that, to aid in the detection and prevention
32 of title insurance company and agent impairments, the
33 board of directors shall carry out certain duties and
34 may exercise certain authority as otherwise provided
35 by Subsection (e). The revised law omits this
36 provision because the other provisions of Subsection
37 (e) establishing those duties and that authority
38 clearly express that intended aim by their own terms.
39 The omitted law reads:

40 (1) To aid in the detection and
41 prevention of insurer and agent
42 impairments, the board shall carry out the
43 duties and may exercise the authority
44 provided by this subsection.

45 Revised Law

46 Sec. 2602.114. MEETING OF BOARD ON IMPAIRED TITLE INSURANCE
47 COMPANY OR AGENT. (a) The commissioner:

48 (1) shall call a meeting of the board when the

1 commissioner determines that a title insurance company or agent is
2 insolvent or impaired; and

3 (2) may call a meeting of the board when the
4 commissioner determines that a title insurance company or agent is
5 in danger of becoming insolvent or impaired.

6 (b) The meeting is not open to the public. Only board
7 members, the commissioner, and persons the commissioner authorizes
8 may attend the meeting.

9 (c) The commissioner may require an officer, director, or
10 employee of the title insurance company or agent to appear before
11 the board for conference or to give testimony.

12 (d) At the meeting the commissioner may disclose to the
13 board information that the commissioner possesses and may disclose
14 department records, including an examination report or a
15 preliminary report from an examiner that relates to the title
16 insurance company or agent.

17 (e) A board member may not disclose information received in
18 the meeting unless authorized by the commissioner or required as
19 witness in court. A board member and the meeting are subject to the
20 confidentiality standard imposed on an examiner under Article 1.18,
21 except that a bond is not required of a board member. (V.T.I.C.
22 Art. 9.48, Sec. 14(e)(3) (part).)

23 Source Law

24 (3) . . . The commissioner shall call a
25 meeting of the board when he determines that an insurer
26 or agent is insolvent or impaired and may call a
27 meeting of the board when he determines that a danger
28 of insolvency or impairment of an insurer or agent
29 exists. Such a meeting is not open to the public and
30 only members of the board of directors, members of the
31 State Board of Insurance, the commissioner, and
32 persons authorized by the commissioner shall attend
33 such meetings. . . . At such meetings the
34 commissioner may divulge to the board any information
35 in his possession and any records of the State Board of
36 Insurance, including examination reports or
37 preliminary reports from examiners relating to such
38 insurer or agent. The commissioner may summon
39 officers, directors, and employees of an insolvent or
40 impaired insurer or agent, or an insurer or agent the
41 commissioner considers to be in danger of insolvency
42 or impairment, to appear before the board for
43 conference or for the taking of testimony. Members of
44 the board shall not reveal information received in

1 such meetings to anyone unless authorized by the
2 commissioner or the State Board of Insurance or when
3 required as witness in court. Board members and all of
4 these meetings shall be subject to the same standard of
5 confidentiality as is imposed upon examiners under
6 Article 1.18 of the Insurance Code, except that no bond
7 shall be required of a board member. . . .

8 Revised Law

9 Sec. 2602.115. ASSOCIATION AND BOARD ADVICE AND
10 ASSISTANCE. (a) On the commissioner's request, the board shall
11 attend hearings before the commissioner and meet with and advise
12 the commissioner or the receiver or the conservator appointed by
13 the commissioner on matters relating to:

14 (1) the affairs of an impaired title insurance company
15 or agent;

16 (2) action that the commissioner, receiver, or
17 conservator may take to best protect the interest of holders of
18 covered claims against the company or agent; and

19 (3) the marshalling of assets.

20 (b) On the commissioner's request, the association may
21 assist and advise the commissioner concerning rehabilitation,
22 payment of claims, continuation of coverage, or the performance of
23 other contractual obligations of an impaired title insurance
24 company or agent. (V.T.I.C. Art. 9.48, Secs. 14(c) (part), (e)(3)
25 (part).)

26 Source Law

27 (c) . . . [the association:]

28 (1) may render assistance and advice to
29 the commissioner, upon his request, concerning
30 rehabilitation, payment of claims, continuations of
31 coverage, or the performance of other contractual
32 obligations of any impaired insurer or agent;
33 . . .

34 [(e)]

35 (3) . . . The board shall, upon request
36 by the commissioner, attend hearings before the
37 commissioner and meet with and advise the
38 commissioner, the receiver or the conservator
39 appointed by the commissioner, on matters relating to
40 the affairs of an impaired insurer or agent and
41 relating to action that may be taken by the
42 commissioner, liquidator, or conservator to best
43 protect the interests of persons holding covered
44 claims against an impaired insurer or agent and
45 relating to the marshalling of assets.

1 Revisor's Note

2 Section 14(e)(3), V.T.I.C. Article 9.48, refers
3 to actions that may be taken by a "liquidator." The
4 revised law substitutes "receiver" for "liquidator"
5 for the reason stated in the revisor's note to Section
6 2602.101.

7 Revised Law

8 Sec. 2602.116. BOARD ACCESS TO RECORDS. The receiver or
9 statutory successor of an impaired title insurance company shall
10 give the board or its representative:

11 (1) access to the company's records as necessary for
12 the board to perform its functions under this chapter relating to
13 covered claims; and

14 (2) copies of those records on the board's request and
15 at the board's expense. (V.T.I.C. Art. 9.48, Sec. 20B (part).)

16 Source Law

17 Sec. 20B. . . . The receiver or statutory
18 successor of an impaired insurer covered by this
19 article shall permit access by the board or its
20 authorized representative to records of the impaired
21 insurer as are necessary for the board in carrying out
22 its functions under this Act with regard to covered
23 claims. In addition, the receiver or statutory
24 successor shall provide the board or its
25 representative with copies of the records on request
26 of the board and at the expense of the board.

27 Revisor's Note

28 Section 20B, V.T.I.C. Article 9.48, refers to an
29 "authorized representative" of the board. The revised
30 law omits "authorized" as unnecessary. An
31 unauthorized representative is not a representative.

32 Revised Law

33 Sec. 2602.117. BOARD REPORT AT CONCLUSION OF
34 IMPAIRMENT. At the conclusion of a title insurance company or
35 agent impairment in which the association exercised its powers or
36 performed its duties under this chapter, the board shall prepare,
37 from information available to the association, and submit to the
38 commissioner a report on the history and causes of the impairment.

1 (V.T.I.C. Art. 9.48, Sec. 14(e)(6).)

2 Source Law

3 (6) At the conclusion of any insurer or
4 agent impairment in which the association carried out
5 its duties under this article or exercised any of its
6 powers under this article, the board shall prepare a
7 report on the history and causes of the impairment,
8 based on the information available to the association,
9 and submit a report on these matters to the
10 commissioner.

11 [Sections 2602.118-2602.150 reserved for expansion]

12 SUBCHAPTER D. POLICY GUARANTY FEES

13 Revised Law

14 Sec. 2602.151. PAYMENT OF FEE. (a) An agent or, if there
15 is no agent, the title insurance company shall pay the association a
16 quarterly guaranty fee for each owner or mortgagee title insurance
17 policy that the agent or company is required to report on its
18 statistical report to the department.

19 (b) The fee is due:

20 (1) May 1, for the quarter ending March 31;

21 (2) August 1, for the quarter ending June 30;

22 (3) November 1, for the quarter ending September 30;

23 and

24 (4) February 1, for the quarter ending December 31.

25 (c) The association shall deposit the fee in the guaranty
26 fee account.

27 (d) Except as provided by Section 2602.109, money in the
28 guaranty fee account shall be derived only from guaranty fees as
29 provided by this subchapter. (V.T.I.C. Art. 9.48, Secs. 6(a)
30 (part), (b), 7(c) (part).)

31 Source Law

32 Sec. 6. (a) The agent, or the insurer if there
33 is no agent, who is required to report an owner or
34 mortgagee title insurance policy on its statistical
35 report to the State Board of Insurance, shall remit a
36 guaranty fee . . . for each owner or mortgagee policy
37 which is required to be reported. . . .

38 (b) Each agent shall remit to the association on
39 a quarterly basis the guaranty fees to be deposited in
40 the guaranty fee account in accordance with this
41 section. The quarterly payment of guaranty fees must
42 be made for the calendar quarters ending March 31st,
43 June 30th, September 30th, and December 31st on or

1 before May 1st, August 1st, November 1st, and February
2 1st, respectively.

3 [Sec. 7]

4 (c) . . . for the guaranty fee account but such
5 funds shall be derived solely from guaranty fees as
6 provided by Section 6 of this article.

7 Revisor's Note

8 (1) Section 6(b), V.T.I.C. Article 9.48,
9 requires certain payments to be made for "calendar
10 quarters" ending on March 31, June 30, September 30,
11 and December 31. The revised law omits as unnecessary
12 the reference to "calendar." The quarters described
13 are "calendar" quarters.

14 (2) Section 7(c), V.T.I.C. Article 9.48, the
15 substance of which was added by Section 1, Chapter
16 1073, Acts of the 70th Legislature, Regular Session,
17 1987, provides that money in the guaranty fee account
18 shall be derived solely from guaranty fees. Section
19 9(b), V.T.I.C. Article 9.48, revised as Section
20 2602.109, the substance of which was added by the same
21 enactment, requires that certain excess amounts in the
22 title account be transferred to the guaranty fee
23 account. Likewise, Section 9(c), V.T.I.C. Article
24 9.48, as added by Chapter 856, Acts of the 75th
25 Legislature, Regular Session, 1997, and revised as
26 Section 2602.109, requires that certain excess amounts
27 in the administrative account be transferred to the
28 guaranty fee account. The revised law acknowledges
29 these exceptions by adding a reference to Section
30 2602.109.

31 Revised Law

32 Sec. 2602.152. AMOUNT OF FEE. Annually or more frequently,
33 the board shall determine the amount of the guaranty fee, not to
34 exceed \$5, considering the amount of money to be maintained in the
35 guaranty fee account that is reasonably necessary for efficient
36 future operation under this chapter. (V.T.I.C. Art. 9.48, Sec.

1 6(a) (part).)

2 Source Law

3 Sec. 6. (a) . . . [a guaranty fee] in an
4 amount not to exceed \$5 The board of directors
5 shall determine at least annually the amount and may
6 adjust the amount more frequently. In determining the
7 amount of the guaranty fee, the board of directors
8 shall take into consideration the amount of funds to be
9 maintained in the guaranty fee account which is
10 reasonably necessary for efficient future operation
11 under the terms of this article.

12 Revised Law

13 Sec. 2602.153. USE OF FEE. (a) The association shall
14 collect, receive, retain, and disburse the guaranty fees only as
15 specifically provided by this chapter.

16 (b) The following covered claims shall be paid from guaranty
17 fees only and may not be paid from assessments:

18 (1) claims against trust funds or an escrow account of
19 an impaired agent under Section 2602.252; and

20 (2) conservator and receiver expenses under Section
21 2602.254.

22 (c) Administrative expenses with respect to the estate of an
23 impaired agent under Section 2602.110 may be paid only from the
24 guaranty fee account.

25 (d) Guaranty fees may be used only for payment of:

26 (1) covered claims described by Subsection (b) or (c);
27 and

28 (2) audit and review expenses under Section
29 2602.103(b). (V.T.I.C. Art. 9.48, Secs. 5(2)A (part), C (part), D
30 (part), 6(c), 14(c) (part).)

31 Source Law

32 Sec. 5. [As used in this article:

33 . . .
34 (2) A. "Covered claim" is an unpaid
35 claim:]

36 (iv) [against trust funds or an
37 escrow account of an impaired agent which arises due to
38 a shortage of those funds or in that account and which]
39 shall be paid only from funds derived from guaranty
40 fees and not from assessments. . . .

41 C. . . . Any funds advanced with
42 regard to the expenses of administering the estate of
43 an impaired agent may be paid only from the guaranty

1 fee account.

2 D. . . .
3 (iii) . . . These
4 administrative expenses shall be paid only from funds
5 derived from guaranty fees and not from assessments.

6 [Sec. 6]

7 (c) Funds derived from guaranty fees shall be
8 authorized only for the payment of the following:

9 (1) "covered claims" as defined by
10 Subparagraph (iv) of Paragraph A and Paragraphs C and D
11 of Subsection (2), Section 5 of this article; and

12 (2) audit expenses as provided by
13 Paragraph (13), Subsection (c), Section 14 of this
14 article.

15 [Sec. 14]

16 (c) . . . [the association:]

17 . . .
18 (13) [shall, on the request of the
19 commissioner, authorize the expenditure of funds] from
20 the guaranty fee account [to retain, compensate, and
21 reimburse for reasonable and necessary expenses, a
22 person or persons who will audit and review] . . . ;

23 (14) shall collect, receive, retain, and
24 disburse the income provided by Section 6 of this
25 article solely for the purposes, to the persons, and
26 under the circumstances that are specifically stated
27 in this article; and
28 . . .

29 Revised Law

30 Sec. 2602.154. ENFORCEMENT OF FEE. (a) After notice and
31 opportunity for hearing, the commissioner may suspend or revoke the
32 certificate of authority or license to engage in business in this
33 state of a title insurance company or agent that does not comply
34 with this subchapter.

35 (b) The commissioner shall adopt rules that implement the
36 program created under this subchapter. (V.T.I.C. Art. 9.48, Secs.
37 6(d), (e).)

38 Source Law

39 (d) The State Board of Insurance shall
40 promulgate rules consistent with this section and
41 conform the program created under this section to
42 applicable statutes, regulations, and rulings.

43 (e) The commissioner may suspend or revoke,
44 after notice and opportunity for hearing, the
45 certificate of authority to transact business in this
46 state of any insurer or agent who fails to comply with
47 this section.

48 Revisor's Note

49 (1) Section 6(d), V.T.I.C. Article 9.48,
50 requires that rules adopted under that section be
51 "consistent with this section" and that they "conform

1 . . . to applicable statutes, regulations, and
2 rulings." The revised law omits the quoted language
3 because a state agency has no authority to act in a
4 manner that is inconsistent with applicable statutes,
5 regulations, and rulings.

6 (2) Section 6(e), V.T.I.C. Article 9.48,
7 provides that the commissioner may suspend or revoke
8 the "certificate of authority" of an agent. The
9 revised law substitutes "license" for "certificate of
10 authority" because under this code, a "license" is the
11 document permitting an agent to engage in business.

12 [Sections 2602.155-2602.200 reserved for expansion]

13 SUBCHAPTER E. ASSESSMENTS

14 Revised Law

15 Sec. 2602.201. MAKING OF ASSESSMENT. (a) If the
16 commissioner determines that a title insurance company or agent has
17 become impaired, the association shall promptly estimate the amount
18 of additional money needed to supplement the assets of the impaired
19 title insurance company or agent to pay all covered claims and
20 administrative expenses.

21 (b) The association shall assess title insurance companies
22 in writing an amount as determined under Section 2602.202. A title
23 insurance company does not incur real or contingent liability under
24 this chapter until the association actually makes the written
25 assessment. (V.T.I.C. Art. 9.48, Secs. 7(a), (b) (part), (f).)

26 Source Law

27 Sec. 7. (a) Whenever the commissioner
28 determines that an insurer or agent has become
29 impaired, the association shall promptly estimate the
30 amount of additional funds needed to supplement the
31 assets of the impaired insurer or agent for the purpose
32 of making payment of all covered claims and
33 administrative expenses.

34 (b) The association shall assess insurers
35 amounts

36 (f) No insurer shall be deemed or considered to
37 have or incur any liability, real or contingent, under
38 the provisions of this Article 9.48 of this Chapter 9
39 until any such assessment shall have been actually
40 made in writing by the association under the

1 provisions of this Article 9.48.

2 Revised Law

3 Sec. 2602.202. AMOUNT OF ASSESSMENT; PRORATION OF
4 PAYMENT. (a) The association shall assess title insurance
5 companies the amount necessary to pay:

6 (1) the association's obligations under this chapter
7 and the expenses of handling covered claims subsequent to an
8 impairment; and

9 (2) other expenses authorized by this chapter.

10 (b) The assessment of each title insurance company must be
11 in the proportion that the net direct written premiums of that
12 company for the calendar year preceding the assessment bear to the
13 net direct written premiums of all title insurance companies for
14 that year.

15 (c) The total assessment of a title insurance company in a
16 year may not exceed an amount equal to two percent of the company's
17 net direct written premiums for the calendar year preceding the
18 assessment. If the maximum assessment and the association's other
19 assets are insufficient in any one year to make all necessary
20 payments, the money available shall be prorated and the unpaid
21 portion shall be paid as soon as money becomes available. (V.T.I.C.
22 Art. 9.48, Sec. 7(b) (part).)

23 Source Law

24 (b) [The association shall assess insurers
25 amounts] necessary to pay the obligations of the
26 association under this article subsequent to an
27 impairment, the expenses of handling covered claims
28 subsequent to an impairment, and other expenses
29 authorized by this article. The assessments of each
30 member insurer shall be in the proportion that the net
31 direct written premiums of the member insurer for the
32 calendar year preceding the assessment bears to the
33 net direct written premiums of all member insurers and
34 for the calendar year preceding the assessment. . . .
35 A member insurer may not be assessed in any year an
36 amount greater than two percent of that member
37 insurer's net direct written premiums for the calendar
38 year preceding the assessment. If the maximum
39 assessment, together with the other assets of the
40 association, does not provide in any one year an amount
41 sufficient to make all necessary payments, the funds
42 available shall be prorated and the unpaid portion
43 shall be paid as soon thereafter as funds become
44 available.

1 Revised Law

2 Sec. 2602.203. NOTICE AND PAYMENT. (a) Not later than the
3 30th day before the date an assessment is due, the association shall
4 notify the title insurance company.

5 (b) Not later than the 30th day after the date an assessment
6 is made, the title insurance company shall pay the association the
7 amount of the assessment. (V.T.I.C. Art. 9.48, Secs. 7(b) (part),
8 (d) (part).)

9 Source Law

10 (b) . . . Each member insurer shall be
11 notified of the assessment not later than the 30th day
12 before the date on which the assessment is due. . . .

13 (d) Each insurer shall pay the amount of its
14 assessment to the association not later than the 30th
15 day after the date on which the assessment is
16 made. . . .

17 Revised Law

18 Sec. 2602.204. EXEMPTION FOR IMPAIRED TITLE INSURANCE
19 COMPANY. A title insurance company is exempt from assessment
20 during the period beginning on the date the commissioner designates
21 the company as an impaired title insurance company and ending on the
22 date the commissioner determines that the company is no longer an
23 impaired title insurance company. (V.T.I.C. Art. 9.48, Sec. 7(g).)

24 Source Law

25 (g) An insurer designated as an impaired insurer
26 by the commissioner is exempt from assessment from and
27 after the date of designation and until the
28 commissioner determines that the insurer is no longer
29 an impaired insurer.

30 Revised Law

31 Sec. 2602.205. DEFERMENT. (a) The association may defer
32 in whole or in part an assessment of a title insurance company that
33 would cause the company's financial statement to show amounts of
34 capital or surplus less than the minimum amount required for a
35 certificate of authority in any jurisdiction in which the company
36 is authorized to engage in the business of insurance.

37 (b) The title insurance company shall pay the deferred
38 assessment when payment will not reduce capital or surplus below

1 required minimums. The payment shall be refunded to or credited
2 against future assessments of any title insurance company receiving
3 a larger assessment because of the deferment, as elected by that
4 company.

5 (c) During a period of deferment, the title insurance
6 company may not pay a dividend to shareholders or policyholders.
7 (V.T.I.C. Art. 9.48, Sec. 7(c) (part).)

8 Source Law

9 (c) The association may defer, in whole or in
10 part, the assessment of any member insurer if the
11 assessment would cause the member insurer's financial
12 statement to reflect amounts of capital or surplus
13 less than the minimum amounts required for a
14 certificate of authority by any jurisdiction in which
15 the member insurer is authorized to transact
16 insurance. During the period of deferment, no
17 dividends may be paid to shareholders or
18 policyholders. Deferred assessments shall be paid when
19 that payment will not reduce capital or surplus below
20 required minimums. These payments shall be refunded
21 to those companies receiving larger assessments by
22 virtue of the deferment, or at the election of such a
23 company, credited against future assessments. . . .

24 Revised Law

25 Sec. 2602.206. PARTICIPATION RECEIPTS. (a) On receipt
26 from a title insurance company of payment of an assessment or
27 partial assessment, the association shall provide the company with
28 a participation receipt. A participation receipt creates liability
29 against the impaired title insurance company.

30 (b) The holder of the receipt is a general creditor of the
31 impaired title insurance company, except that if the amount of
32 assessments the association receives exceeds the amount paid for
33 covered claims, the holders of participation receipts have
34 preference over other general creditors to, and are entitled to
35 share pro rata in, the excess. (V.T.I.C. Art. 9.48, Sec. 9(a)
36 (part).)

37 Source Law

38 Sec. 9. (a) Upon receipt from an insurer of
39 payment of an assessment or partial assessment, the
40 association shall provide the insurer with a
41 participation receipt which shall create a liability
42 against the impaired insurer, and the holder of such
43 participation receipt shall be regarded as a general
44 creditor of the impaired insurer; provided, however,

1 that with reference to the remaining balance of any
2 portions of assessments received by the association
3 and not expended in payment of "covered claims," the
4 holders of such participation receipts shall have
5 preference over other general creditors and shall
6 share pro rata with other holders of participation
7 receipts. . . .

8 Revised Law

9 Sec. 2602.207. ACCOUNTING; REPORTS; REFUND. (a) The
10 association shall adopt accounting procedures to show how money
11 received from assessments or partial assessments is used.

12 (b) The association shall make interim accounting reports
13 as the commissioner requires.

14 (c) The association shall make a final report to the
15 commissioner showing how money received from assessments or partial
16 assessments has been used, including a statement of any final
17 balance of that money. As soon as practicable after completion of
18 the final report, the association shall refund the remaining
19 balance to the holders of participation receipts as required by
20 Section 2602.206(b). (V.T.I.C. Art. 9.48, Sec. 9(a) (part).)

21 Source Law

22 (a) . . . The association shall adopt
23 accounting procedures reflecting the expenditure and
24 use of all funds received from assessments or partial
25 assessments and shall make a final report of the
26 expenditure and use of such funds to the commissioner,
27 which final report shall set forth the remaining
28 balance, if any, from the funds collected by
29 assessment. The association shall also make any
30 interim reports concerning such accounting as may be
31 required by the commissioner. Upon completion of the
32 final report, the association shall, as soon
33 thereafter as is practicable, refund pro rata the
34 remaining balance of such assessments to the holders
35 of the participation receipts.

36 Revisor's Note

37 Section 9(a), V.T.I.C. Article 9.48, refers to
38 the "expenditure and use" of money. The revised law
39 omits the reference to "expenditure" as unnecessary
40 because "expenditure" is included within the meaning
41 of "use."

42 Revised Law

43 Sec. 2602.208. USE OF ASSESSMENTS. (a) Money from
44 assessments is considered to supplement the marshalling of an

1 impaired title insurance company's assets to make payments on the
2 impaired title insurance company's behalf. The association may
3 assess title insurance companies or use money from assessments to
4 pay covered claims before the receiver exhausts the impaired title
5 insurance company's assets.

6 (b) The association may use money from assessments to
7 negotiate and consummate contracts of reinsurance or assumption of
8 liabilities or contracts of substitution to provide for outstanding
9 liabilities of covered claims.

10 (c) Except as provided by Section 2602.109, money from
11 assessments may not be used for the guaranty fee account. (V.T.I.C.
12 Art. 9.48, Secs. 7(c) (part), 7A, 10(i) (part).)

13 Source Law

14 [Sec. 7]

15 (c) . . . No assessment shall be made to
16 produce funds for the guaranty fee account

17 Sec. 7A. (a) The amounts provided pursuant to
18 assessments made under this article are considered to
19 be supplemental to the marshaling of assets for the
20 purpose of making payments on behalf of an impaired
21 insurer.

22 (b) The association may assess its insurers or
23 use funds derived from assessments to pay covered
24 claims before the receiver exhausts the assets of the
25 impaired insurer.

26 [Sec. 10]

27 (i) In addition to authorization to make actual
28 payment of covered claims, the association may use
29 funds derived from assessments for the purpose of
30 negotiating and consummating contracts of reinsurance
31 or assumption of liabilities or contracts of
32 substitution to provide for outstanding liabilities of
33 covered claims. . . .

34 Revisor's Note

35 Section 7(c), V.T.I.C. Article 9.48, provides
36 that an assessment may not be made to produce money for
37 the guaranty fee account. The revised law adds a
38 reference to an exception revised in Section 2602.109
39 for the reason stated in Revisor's Note (2) to Section
40 2602.151.

41 Revised Law

42 Sec. 2602.209. FAILURE TO PAY; COLLECTION BY

1 COMMISSIONER. (a) The association shall promptly report to the
2 commissioner a failure of a title insurance company to pay an
3 assessment when due.

4 (b) On failure of a title insurance company to pay an
5 assessment when due, the commissioner may either:

6 (1) suspend or revoke, after notice and hearing, the
7 company's certificate of authority to engage in business in this
8 state; or

9 (2) assess an administrative penalty as provided by
10 Chapter 84 in an amount not to exceed the greater of five percent of
11 the unpaid assessment each month or \$100 each month.

12 (c) A title insurance company whose certificate of
13 authority is canceled or surrendered is liable for any unpaid
14 assessments made before the date of the cancellation or surrender.

15 (d) The commissioner may collect an assessment on behalf of
16 the association through a suit brought for that purpose. (V.T.I.C.
17 Art. 9.48, Secs. 7(d) (part), 8.)

18 Source Law

19 [Sec. 7]

20 (d) . . . The commissioner may collect the
21 assessments on behalf of the association through suits
22 brought for that purpose.

23 Sec. 8. (a) The commissioner may suspend or
24 revoke, after notice and hearing, the certificate of
25 authority to transact business in this state of any
26 insurer who fails to pay an assessment when due, and
27 the association shall promptly report the failure to
28 pay to the commissioner. As an alternative, the
29 commissioner may assess an administrative penalty in
30 accordance with Article 1.10E of this code on any
31 insurer that fails to pay an assessment when due. The
32 fine may not exceed the greater of five percent of the
33 unpaid assessment per month or \$100 per month.

34 (b) Any insurer whose certificate or authority
35 to do business in this state is canceled or surrendered
36 shall be liable for any unpaid assessments made prior
37 to the date of such cancellation or surrender.

38 Revised Law

39 Sec. 2602.210. RECOVERY OF ASSESSMENT IN RATES; TAX
40 CREDIT. (a) A title insurance company is entitled to recover in
41 its rates for the succeeding calendar year amounts paid in
42 assessments not to exceed one percent of the company's net direct

1 written premiums. In promulgating or establishing rates the
2 commissioner shall consider assessments and refunds of assessments
3 and shall adjust the rates to allow for recovery under this
4 subsection.

5 (b) Unless the department determines that all amounts paid
6 as assessments by each title insurance company have been recovered
7 under Subsection (a), for any amount not recovered the title
8 insurance company is entitled to a credit against its premium tax
9 under Chapter 223. The credit may be taken at a rate of 20 percent
10 each year for five successive years following the date of
11 assessment and, if the title insurance company elects, may be taken
12 over an additional number of years.

13 (c) An amount of a tax credit allowed by this section that is
14 unclaimed may be shown in the title insurance company's books and
15 records as an admitted asset for all purposes, including an annual
16 statement under Section 862.001. (V.T.I.C. Art. 9.48, Sec. 15.)

17 Source Law

18 Sec. 15. Insurers shall be entitled to recoup
19 assessments up to one percent of their net direct
20 written premiums from rates promulgated, established,
21 or approved by the State Board of Insurance in the next
22 calendar year. The State Board of Insurance in
23 promulgating, establishing, or approving rates shall
24 take into account assessments and refunds of
25 assessments made in accordance with this article and
26 shall include in the formula forming the basis for
27 promulgating, establishing, or approving rates sums
28 sufficient to provide for recoupment by the insurers
29 of said assessments of up to one percent.

30 Unless the State Board of Insurance has
31 determined that all amounts paid by each insurer on
32 assessments on total net direct written premiums have
33 been included in the rates and premiums as provided
34 above, any amounts not so included shall be allowed to
35 such insurer as a credit against its premium tax under
36 Article 9.59 of this code. The tax credit referred to
37 herein shall be allowed at a rate of 20 percent per
38 year for five successive years following the date of
39 assessment and at the option of the insurer may be
40 taken over an additional number of years, and the
41 balance of any assessment paid by the insurer and not
42 claimed as a tax credit may be reflected in the books
43 and records of the insurer as an admitted asset of the
44 insurer for all purposes, including exhibition in
45 annual statements under Article 6.12 of this code.

46 Revisor's Note

47 Section 15, V.T.I.C. Article 9.48, refers to

1 premium rates being "promulgated, established, or
2 approved." The revised law omits the references to
3 approval of rates because this title does not include a
4 provision for approval of rates.

5 [Sections 2602.211-2602.250 reserved for expansion]

6 SUBCHAPTER F. COVERED CLAIMS

7 Revised Law

8 Sec. 2602.251. COVERED CLAIMS IN GENERAL. An unpaid claim
9 is a covered claim if:

10 (1) the claim is made by an insured under a title
11 insurance policy to which this chapter applies;

12 (2) the claim arises out of the policy and is within
13 the coverage and applicable limits of the policy;

14 (3) the title insurance company that issued the policy
15 or assumed the policy under an assumption certificate is an
16 impaired title insurance company; and

17 (4) the insured real property or a lien on the property
18 is located in this state. (V.T.I.C. Art. 9.48, Sec. 5(2)A (part).)

19 Source Law

20 (2) A. "Covered claim" is an unpaid
21 claim:

22 (i) of an insured which arises
23 out of and is within the coverage and not in excess of
24 the applicable limits of a title insurance policy to
25 which this article applies, issued or assumed (whereby
26 an assumption certificate is issued) by an insurer
27 licensed to do business in this state and covered by
28 this article, if such insurer becomes an "impaired
29 insurer" after the effective date of this article and
30 the insured real property (or lien thereon) is located
31 within this state;

32 . . .

33 Revisor's Note

34 Section 5(2)A, V.T.I.C. Article 9.48, refers to a
35 title insurance company that becomes an impaired title
36 insurance company "after the effective date of this
37 article." The article to which this language refers
38 was enacted by Chapter 409, Acts of the 64th
39 Legislature, Regular Session, 1975, which took effect
40 September 1, 1975. The revised law omits the quoted

1 language as unnecessary because any claim involving a
2 title insurance company that became an impaired title
3 insurance company before that date must have been
4 resolved before the enactment of this revision.

5 Revised Law

6 Sec. 2602.252. CLAIM AGAINST TRUST FUNDS OR ESCROW
7 ACCOUNT. An unpaid claim is a covered claim if the claim:

8 (1) is against trust funds or an escrow account of an
9 impaired title insurance company or agent; and

10 (2) is unpaid because of a shortage of those funds or
11 in that account. (V.T.I.C. Art. 9.48, Sec. 5(2)A (part).)

12 Source Law

13 (2) A. "Covered claim" is an unpaid
14 claim:

15
16 (ii) against trust funds or an
17 escrow account of an impaired insurer which arises due
18 to a shortage of those funds or in that account;

19
20 (iv) against trust funds or an
21 escrow account of an impaired agent which arises due to
22 a shortage of those funds or in that account and
23 which

24 Revised Law

25 Sec. 2602.253. CLAIM IN CONNECTION WITH FIDELITY OF
26 AGENT. An unpaid claim is a covered claim if an impaired title
27 insurance company is liable for the claim in connection with the
28 fidelity of the company's agent as authorized by Subchapter A,
29 Chapter 2702. (V.T.I.C. Art. 9.48, Sec. 5(2)A (part).)

30 Source Law

31 (2) A. "Covered claim" is an unpaid
32 claim:

33
34 (iii) for which an impaired
35 insurer is liable in connection with the fidelity of
36 any agent of that insurer as authorized by Article 9.49
37 of this code; or

38

39 Revised Law

40 Sec. 2602.254. CERTAIN CONSERVATOR AND RECEIVER EXPENSES
41 COVERED. Reasonable and necessary administrative expenses
42 incurred by a conservator appointed by the commissioner or a

1 receiver appointed by a court for an unauthorized insurer operating
2 in this state are covered claims if the commissioner has notified
3 the association or the association has otherwise become aware that:

4 (1) the unauthorized insurer has insufficient liquid
5 assets to pay those expenses; and

6 (2) insufficient money is available from:

7 (A) abandoned money under Section 8, Article
8 21.28; and

9 (B) department appropriations for use in paying
10 those expenses. (V.T.I.C. Art. 9.48, Sec. 5(2)D (part).)

11 Source Law

12 D. Reasonable and necessary
13 administrative expenses incurred by a conservator
14 appointed by the commissioner or a receiver appointed
15 by a court of competent jurisdiction for an
16 unauthorized insurer operating in this state is a
17 "covered claim" under this article if the commissioner
18 has notified the association or the association has
19 otherwise become aware that:

20 (i) the unauthorized insurer
21 has insufficient liquid assets to pay the expenses of
22 administering the receivership or conservatorship of
23 the unauthorized insurer;

24 (ii) insufficient funds are
25 available from abandoned funds as provided by Section
26 8, Article 21.28 of this code; and

27 (iii) insufficient funds are
28 available to the State Board of Insurance from
29 appropriations for use in meeting those administrative
30 expenses. . . .

31 Revised Law

32 Sec. 2602.255. CLAIMS NOT COVERED. The following are not
33 covered claims:

34 (1) an amount due a reinsurer, title insurance
35 company, insurance pool, or underwriting association as a
36 subrogation recovery or otherwise;

37 (2) a supplementary payment obligation incurred
38 before a determination is made under this chapter that a title
39 insurance company or agent is impaired, including:

40 (A) adjustment fees or expenses;

41 (B) attorney's fees or expenses;

42 (C) court costs;

43 (D) interest;

1 (E) enhanced damages, sought as a recovery
2 against the insured, the impaired title insurance company or agent,
3 or the association, that arise under Chapter 541 of this code or
4 Subchapter E, Chapter 17, Business & Commerce Code; and

5 (F) bond premiums;

6 (3) a shortage of trust funds or in an escrow account
7 resulting from the insolvency of a financial institution;

8 (4) exemplary, extracontractual, or bad faith damages
9 awarded against an insured or title insurance company by a court
10 judgment;

11 (5) a claim under Section 2602.252 by a claimant who
12 has a lien against the real property that was the subject of the
13 transaction from which the claim arises, unless the lien is held to
14 be invalid as a matter of law;

15 (6) a claim under Section 2602.251, 2602.252, or
16 2602.253 by a claimant who caused or substantially contributed to
17 the claimant's loss by the claimant's action or omission; and

18 (7) a claim filed with the association after the final
19 date set by the court for the filing of claims against a receiver of
20 an impaired title insurance company or agent. (V.T.I.C. Art. 9.48,
21 Secs. 5(2)B, 10(c).)

22 Source Law

23 [Sec. 5(2)]

24 B. "Covered claim" shall not include
25 any amount due any reinsurer, insurer, insurance pool,
26 or underwriting association, as subrogation
27 recoveries or otherwise. "Covered claim" shall not
28 include supplementary payment obligations, including
29 but not limited to adjustment fees and expenses,
30 attorneys' fees and expenses, court costs, interest,
31 enhanced damages, whether sought as a recovery against
32 the insured, the impaired insurer, the impaired agent,
33 or the association, that arise under Article 21.21 of
34 this code or under the Deceptive Trade
35 Practices-Consumer Protection Act (Section 17.41 et
36 seq., Business & Commerce Code), and bond premiums,
37 incurred prior to the determination that an insurer or
38 agent is "impaired" under this article. "Covered
39 claim" shall also not include any shortage of trust
40 funds, shortage in an escrow account resulting from
41 the insolvency of a financial institution, or
42 punitive, exemplary, extracontractual, or bad faith
43 damages awarded by a court judgment against an insured
44 or insurer. A "covered claim" does not include a claim
45 under Subparagraph (ii) or (iv) of Paragraph A of

1 Subdivision (2) of Section 5 if the claimant has a lien
2 against the real estate that was the subject of the
3 transaction from which the claim arises unless that
4 lien is held to be invalid as a matter of law. No
5 claimant who has caused or substantially contributed
6 to his loss by his action or failure to act shall have a
7 covered claim under Paragraph A of Subdivision (2) of
8 Section 5.

9 [Sec. 10]

10 (c) Notwithstanding any other provisions of
11 this article, a covered claim does not include a claim
12 filed with the association after the final date set by
13 the court for the filing of claims against the receiver
14 of an impaired insurer or agent.

15 Revisor's Note

16 (1) Section 5(2)B, V.T.I.C. Article 9.48,
17 refers to "including but not limited to." The revised
18 law omits "but not limited to" as unnecessary because
19 Section 311.005(13), Government Code (Code
20 Construction Act), and Section 312.011(19),
21 Government Code, provide that "includes" and
22 "including" are terms of enlargement and not of
23 limitation and do not create a presumption that
24 components not expressed are excluded.

25 (2) Section 5(2)B, V.T.I.C. Article 9.48,
26 states that a covered claim does not include "any
27 shortage of trust funds, [or] shortage in an escrow
28 account resulting from the insolvency of a financial
29 institution." It is clear that the reference to a
30 shortage "resulting from the insolvency of a financial
31 institution" must apply to a shortage of trust funds as
32 well as a shortage in an escrow account. Sections
33 5(2)A(ii) and (iv), V.T.I.C. Article 9.48, revised in
34 part as Section 2602.252, state that a shortage in a
35 trust fund or escrow account in general is a covered
36 claim. Therefore, to avoid making that general rule
37 meaningless in relation to a shortage of trust funds,
38 the exception created by Section 5(2)B must be limited
39 to a shortage resulting from insolvency of a financial
40 institution. The revised law is drafted accordingly.

1 (3) Section 5(2)B, V.T.I.C. Article 9.48,
2 excludes from treatment as a covered claim certain
3 "punitive" or "exemplary" damages. The revised law
4 omits the reference to "punitive" because under
5 Section 41.001, Civil Practice and Remedies Code,
6 "exemplary damages" is defined to include "punitive
7 damages." Chapter 41, Civil Practice and Remedies
8 Code, is the general law governing exemplary damages
9 in this state.

10 (4) Section 5(2)B, V.T.I.C. Article 9.48,
11 refers to a claimant's "action or failure to act." The
12 revised law substitutes "action or omission" for the
13 quoted language for consistency in use of terminology
14 throughout this chapter.

15 Revised Law

16 Sec. 2602.256. AMOUNT OF COVERED CLAIM; LIMIT. (a) A
17 covered claim under Section 2602.251 or 2602.253 may not exceed the
18 lesser of \$250,000 for each claimant or \$250,000 for each policy.

19 (b) A covered claim under Section 2602.252 may not exceed
20 the lesser of \$250,000 for each claimant or the amount of money
21 actually delivered to the impaired title insurance company or agent
22 as trust funds or an escrow account for each claimant in a
23 transaction from which the claim arises, except that the cumulative
24 amount of covered claims arising from a single transaction may not
25 exceed \$250,000. (V.T.I.C. Art. 9.48, Sec. 5(2)A (part).)

26 Source Law

27 (2) A. . . . A "covered claim" under
28 Subparagraphs (i) and (iii) of this paragraph shall be
29 limited to the lesser of \$250,000 per claimant or
30 \$250,000 per policy. The amount of a "covered claim"
31 under Subparagraph (ii) and (iv) of this paragraph is
32 the amount of the unpaid claim up to and not to exceed,
33 the lesser of the amount of funds actually delivered to
34 the impaired insurer or agent as trust funds or an
35 escrow account for each claimant in a transaction from
36 which the claim arises or \$250,000 per claimant,
37 provided that the cumulative amount of covered claims
38 arising from one transaction may not exceed \$250,000.

1 Revised Law

2 Sec. 2602.257. EXHAUSTION OF OTHER RIGHTS
3 REQUIRED. (a) A person having a covered claim that is also a
4 claim against a title insurance company under law or under an
5 insurance policy other than a policy of an impaired title insurance
6 company must exhaust the person's rights under law or the policy
7 before asserting the covered claim under this chapter.

8 (b) The amount payable on the covered claim is reduced by
9 the amount of any recovery under law or the policy.

10 (c) Notwithstanding any other provision, to avoid undue
11 hardship to a claimant the association may authorize payment of a
12 covered claim against an impaired agent without regard to the
13 liability of any title insurance company or coverage under any
14 insurance policy, subject to the approval of the receivership court
15 or commissioner, as applicable. On payment, the association is in
16 all respects subrogated to the rights and claims of the claimant.
17 (V.T.I.C. Art. 9.48, Sec. 12.)

18 Source Law

19 Sec. 12. (a) A person having a claim against an
20 insurer under law or under any provision in an
21 insurance policy other than a policy of an impaired
22 insurer, which claim is also a covered claim, must
23 first exhaust his rights under law or under the policy,
24 and any amount payable on a covered claim under this
25 article shall be reduced by the amount of any recovery
26 under law or under the policy.

27 (b) Notwithstanding any provision to the
28 contrary, the association, for the purpose of avoiding
29 undue hardship to a claimant, subject to the approval
30 of the receivership court or the commissioner, as the
31 case may be, may authorize payment of covered claims
32 against an impaired agent without regard to the
33 liability of any insurer or to coverage under any
34 insurance policy. On payment, the association is in
35 all respects subrogated to the rights and claims of the
36 claimant.

37 Revised Law

38 Sec. 2602.258. CERTAIN MONEY AUTHORIZED FOR USE IN PAYING
39 COVERED CLAIM; LIMIT. (a) Money from assessments or guaranty
40 fees is liable only for the difference between the amount of covered
41 claims and the amount of assets marshalled by a receiver or
42 conservator for payment to holders of covered claims.

1 (b) In an ancillary receivership in this state, money from
2 assessments is liable only for the difference between the amount of
3 covered claims and the amount of assets marshalled by receivers in
4 other states for payment of covered claims in this state. (V.T.I.C.
5 Art. 9.48, Secs. 11(a), (b) (part).)

6 Source Law

7 Sec. 11. (a) Funds received from assessments
8 or from guaranty fees shall be liable only for the
9 difference between the amount of the covered claims
10 and the amount of the assets marshalled by the receiver
11 for payment to holders of covered claims. In ancillary
12 receiverships in this state, funds received from
13 assessments shall be liable only for the difference
14 between the amount of the covered claims and the amount
15 of assets marshalled by the receivers in other states
16 for application to payment of covered claims within
17 this state.

18 (b) . . . When an impaired insurer or agent has
19 been placed in conservatorship, the funds received
20 from assessments or from guaranty fees shall be liable
21 only for the difference between the amount of the
22 covered claim approved by the conservator and the
23 amount of assets marshalled by the conservator for
24 payment to holders of covered claims.

25 Revisor's Note

26 Section 11(b), V.T.I.C. Article 9.48, provides
27 that if a conservator is appointed to handle the
28 affairs of an impaired title insurance company or
29 agent, the liability of money received from
30 assessments or guaranty fees is determined based on
31 the amount of the covered claim "approved by the
32 conservator." The revised law omits the quoted
33 language as unnecessary because, under the part of
34 Section 11(b), V.T.I.C. Article 9.48, revised as
35 Section 2602.351, and the part of Section 11(c),
36 V.T.I.C. Article 9.48, revised as Section 2602.354, in
37 that situation all covered claims must be approved by
38 the conservator.

39 Revised Law

40 Sec. 2602.259. STAY OF PROCEEDINGS; CERTAIN DECISIONS NOT
41 BINDING. (a) To permit the receiver or association to properly
42 defend a pending cause of action, a proceeding in which an impaired

1 title insurance company is a party or is obligated to defend a party
2 in a court in this state, other than a proceeding directly related
3 to the receivership or instituted by the receiver, is stayed for:

4 (1) a six-month period beginning on the later of the
5 date of the designation of impairment or the date an ancillary
6 proceeding is brought in this state; and

7 (2) any subsequent period as determined by the court.

8 (b) If a covered claim arises from a judgment, order,
9 verdict, finding, or other decision based on the default of an
10 impaired title insurance company or its failure to defend an
11 insured, the association on its own behalf or on behalf of the
12 insured may apply to the court or administrator that made the
13 decision to have the decision set aside and may defend the claim on
14 its merits.

15 (c) In a proceeding considering a covered claim, a judgment
16 against an insured taken after the date the delinquency proceeding
17 begins or a conservator is appointed is not evidence of liability or
18 of the amount of damages, and a default or consent judgment against
19 an insured or the impaired title insurance company or a settlement,
20 release, or judgment entered into by the insured or the impaired
21 title insurance company does not bind the association and is not
22 evidence of liability or of the amount of damages in connection with
23 a claim brought against the association or another party under this
24 chapter. (V.T.I.C. Art. 9.48, Secs. 11(c) (part), 20B (part).)

25 Source Law

26 [Sec. 11]

27 (c) . . . In the proceedings of considering
28 "covered claims," no judgment against an insured taken
29 after the date of the commencement of the delinquency
30 proceedings or the appointment of a conservator shall
31 be considered as evidence of liability, or of the
32 amount of damages, and no judgment taken by default or
33 consent against an insured or the impaired insurer and
34 any settlement, release, or judgment entered into by
35 the insured or the impaired insurer may not be
36 considered to be binding on the association and may not
37 be considered as evidence of the liability or of
38 damages in connection with any claim brought against
39 the association or any other party under this article.

40 Sec. 20B. All proceedings in which an impaired
41 insurer is a party or is obligated to defend a party in

1 any court in this state, except proceedings directly
2 related to the receivership or instituted by the
3 receiver, shall be stayed for six months and any
4 additional time thereafter as may be determined by the
5 court from the date of the designation of impairment or
6 an ancillary proceeding is instituted in the state,
7 whichever is later, to permit proper defense by the
8 receiver or the association of all pending causes of
9 action. As to any covered claims arising from a
10 judgment under any decision, verdict, or finding based
11 on the default of the impaired insurer or its failure
12 to defend an insured, the association either on its own
13 behalf or on behalf of the insured may apply to have
14 the judgment, order, decision, verdict, or finding set
15 aside by the same court or administrator that made the
16 judgment, order, decision, verdict, or finding and
17 shall be permitted to defend the claim on the merits.
18 . . .

19 Revised Law

20 Sec. 2602.260. ADMISSIBILITY OF PAYMENT. In a lawsuit
21 brought by a conservator or receiver of an impaired title insurance
22 company or agent to recover assets of the company or agent, the fact
23 that a claim against the company or agent has been or will be paid
24 under this chapter is not admissible and may not be placed before a
25 jury by evidence, argument, or reference. (V.T.I.C. Art. 9.48,
26 Sec. 19(a).)

27 Source Law

28 Sec. 19. (a) In any lawsuit brought by a
29 conservator or receiver of an impaired insurer or
30 agent for the purpose of recovering assets of the
31 impaired insurer or agent, the fact that claims
32 against the impaired insurer or agent have been or will
33 be paid under this article is not admissible for any
34 purpose and may not be placed before any jury by
35 evidence, argument, or reference in any manner.

36 Revisor's Note

37 Section 19(a), V.T.I.C. Article 9.48, provides
38 that certain evidence is not admissible "for any
39 purpose" and that it may not be placed before a jury
40 "in any manner." The revised law omits "for any
41 purpose" and "in any manner" as unnecessary. If
42 evidence is not admissible, it is not admissible for
43 any purpose. If evidence may not be placed before a
44 jury, it may not be placed before the jury in any
45 manner.

46 [Sections 2602.261-2602.300 reserved for expansion]

1 SUBCHAPTER G. ASSOCIATION POWERS AND DUTIES RELATING
2 TO COVERED CLAIMS

3 Revised Law

4 Sec. 2602.301. GENERAL POWERS AND DUTIES OF ASSOCIATION IN
5 CONNECTION WITH PAYMENT OF COVERED CLAIMS. (a) The association
6 shall:

7 (1) investigate a claim brought against the
8 association, the commissioner, or a special deputy receiver
9 appointed under Article 21.28 if the claim involves or may involve
10 the association's rights and obligations under this chapter; and

11 (2) adjust, compromise, settle, and pay a covered
12 claim to the extent of the association's obligation, and deny all
13 other claims.

14 (b) The association may review a settlement, release, or
15 judgment to which an impaired title insurance company or agent or
16 its insured was a party to determine the extent to which the
17 settlement, release, or judgment is contested. (V.T.I.C.
18 Art. 9.48, Sec. 10(e).)

19 Source Law

20 (e) The association shall investigate claims
21 brought against the association, the commissioner, or
22 a special deputy receiver appointed under Article
23 21.28 of this code if the claims involve or may involve
24 the association's rights and obligations under this
25 article, and shall adjust, compromise, settle, and pay
26 covered claims to the extent of the association's
27 obligation, and deny all other claims. The
28 association may review settlements, releases, and
29 judgments to which the impaired insurer or agent or its
30 insureds were parties to determine the extent to which
31 the settlements, releases, and judgments are
32 contested.

33 Revised Law

34 Sec. 2602.302. PAYMENT OF COVERED CLAIMS. (a) The
35 association shall pay covered claims:

36 (1) existing before the determination of impairment;
37 or

38 (2) arising on or before:
39 (A) the date of cancellation of the impaired
40 title insurance company's policies; or

1 (B) the claim deadline for covered claims against
2 an impaired agent.

3 (b) The court in which the receivership proceedings are
4 pending shall set, as applicable:

5 (1) the date of cancellation of the policies, which
6 may not be later than the fifth anniversary of the date of
7 determination of impairment; or

8 (2) the claim deadline, which may not be later than the
9 first anniversary of the date of determination of impairment.

10 (c) Subject to the approval of the commissioner, the
11 association shall establish:

12 (1) procedures for filing claims with the association;
13 and

14 (2) acceptable forms of proof of covered claims.

15 (d) The association shall pay claims in the order the
16 association considers reasonable, including payment as claims are
17 received from the claimants or in groups or categories of claims.

18 (e) The association may not pay a claimant an amount
19 exceeding the amount of the claimant's covered claim. (V.T.I.C.
20 Art. 9.48, Secs. 10(a), (b), (f), (g) (part).)

21 Source Law

22 Sec. 10. (a) The association shall pay covered
23 claims existing before the determination of the
24 impairment or arising on or before the date of
25 cancellation of the policies of the impaired insurer
26 or of the claim deadline for covered claims against an
27 impaired agent. The court in which the receivership
28 proceedings are pending shall set the date of
29 cancellation of the policies and that date may not be
30 later than the date five years after the determination
31 of impairment. The court shall set the claim deadline
32 and that deadline may not be later than one year after
33 the determination of impairment.

34 (b) The association may not pay a claimant an
35 amount in excess of the amount of the covered claim.

36 (f) The association shall pay claims in any
37 order it considers reasonable, including the payment
38 of claims as those claims are received from the
39 claimants or in groups or categories of claims.

40 (g) Subject to the approval of the commissioner,
41 the association shall establish procedures by which
42 claims may be filed with the association and
43 acceptable forms of proof of covered claims. . . .

1 Revised Law

2 Sec. 2602.303. SERVICING FACILITY. (a) The association
3 may handle claims through its employees or through one or more title
4 insurance companies or other persons designated, subject to the
5 approval of the commissioner, as a servicing facility.

6 (b) A title insurance company may decline designation as a
7 servicing facility.

8 (c) The association shall reimburse a servicing facility
9 for:

10 (1) obligations of the association paid by the
11 facility; and

12 (2) expenses incurred by the facility in handling
13 claims for the association. (V.T.I.C. Art. 9.48, Sec. 10(h).)

14 Source Law

15 (h) The association may handle claims through
16 its employees or through one or more insurers or other
17 persons designated as servicing facilities.
18 Designation of a servicing facility is subject to the
19 approval of the commissioner. Designation as a
20 servicing facility may be declined by a member
21 insurer. The association shall reimburse each
22 servicing facility for obligations of the association
23 paid by the facility and for expenses incurred by the
24 facility while handling claims on behalf of the
25 association.

26 Revised Law

27 Sec. 2602.304. ADVANCE AS LOAN. Money advanced by the
28 association under this chapter is considered a special fund loan to
29 the impaired title insurance company or agent for payment of
30 covered claims and does not become an asset of the title insurance
31 company or agent. The loan is repayable to the extent money from
32 the title insurance company or agent is available. (V.T.I.C.
33 Art. 9.48, Sec. 10(j).)

34 Source Law

35 (j) Funds advanced by the association under this
36 article do not become assets of the impaired insurer or
37 the impaired agent but are considered special fund
38 loans to the impaired insurer or the impaired agent for
39 payment of covered claims. That loan is repayable to
40 the extent available from the funds of the impaired
41 insurer or the impaired agent.

1 Revised Law

2 Sec. 2602.305. ASSOCIATION IN PLACE OF IMPAIRED TITLE
3 INSURANCE COMPANY OR AGENT. (a) To the extent of the
4 association's obligation on a covered claim, the association stands
5 in the place of the impaired title insurance company or agent and
6 has all the rights, duties, and obligations of the company or agent
7 as if the company or agent were not impaired.

8 (b) In performing its obligations under this chapter, the
9 association is not considered:

10 (1) to be engaged in the business of insurance;

11 (2) to have assumed or succeeded to a liability of the
12 impaired title insurance company or agent; or

13 (3) to otherwise stand in the place of the impaired
14 title insurance company or agent, including as to whether the
15 association is subject to personal jurisdiction of the courts of
16 another state. (V.T.I.C. Art. 9.48, Sec. 10(d).)

17 Source Law

18 (d) The association stands in the place of the
19 impaired insurer or agent to the extent of its
20 obligation on the covered claims and, to that extent,
21 has all rights, duties, and obligations of the
22 impaired insurer or agent as if the insurer or agent
23 had not become impaired. In performing its
24 obligations under this article, the association shall
25 not be considered to be in the business of insurance,
26 shall not be considered to have assumed or succeeded to
27 any liabilities of the impaired insurer or the
28 impaired agent, and shall not be considered to
29 otherwise stand in the shoes of the impaired insurer or
30 the impaired agent for any purpose, including, but not
31 limited to, the issue of whether the association is
32 amenable to the personal jurisdiction of the courts of
33 any other state.

34 Revisor's Note

35 Section 10(d), V.T.I.C. Article 9.48, refers to
36 "including, but not limited to." "[B]ut not limited
37 to" is omitted for the reason stated in Revisor's Note
38 (1) to Section 2602.255.

39 Revised Law

40 Sec. 2602.306. ASSIGNMENT OF CLAIMANT'S RIGHTS. (a) Any
41 cause of action or other right of the holder of a covered claim

1 arising from the occurrence on which the claim is based is assigned
2 to the association on the holder's acceptance of:

3 (1) the association's payment of the claim; or

4 (2) a benefit of a contract by the association
5 providing for reinsurance or assumption of liabilities or for
6 substitution.

7 (b) Rights are assigned to the association under Subsection
8 (a) to the extent of the amount accepted or the value of the benefit
9 provided.

10 (c) The association may assign the rights acquired under
11 this section to the title insurance company executing the
12 reinsurance, assumption, or substitution agreement. (V.T.I.C.
13 Art. 9.48, Sec. 11(d).)

14 Source Law

15 (d) The acceptance of payment from the
16 association by the holder of a covered claim or the
17 acceptance of the benefits of contracts by the
18 association providing for reinsurance or assumption of
19 liabilities or for substitution shall constitute an
20 assignment to the association of any cause of action or
21 right of the holder of such covered claim arising from
22 the occurrence upon which the covered claim is based.
23 Such assignment shall be to the extent of the amount
24 accepted or the value of the benefits provided by such
25 contracts of reinsurance or assumption of liabilities
26 or substitution. Such assignment to the association
27 may be assigned to the insurer executing such
28 reinsurance, assumption or substitution agreement.

29 Revised Law

30 Sec. 2602.307. SETTLEMENT BY ASSOCIATION BINDING; PRIORITY
31 OF CLAIM AND EXPENSES. (a) The settlement of a covered claim by
32 the association binds the receiver or statutory successor of an
33 impaired title insurance company.

34 (b) The court shall give the covered claim the same priority
35 against assets of the impaired title insurance company that the
36 claim would have had in the absence of this chapter.

37 (c) The association's expenses in handling claims have the
38 same priority as the receiver's expenses. (V.T.I.C. Art. 9.48,
39 Sec. 11(e).)

1 Source Law

2 (e) The receiver or statutory successor of an
3 impaired insurer is bound by settlements of covered
4 claims by the association. The court having
5 jurisdiction shall grant those claims priority equal
6 to that to which the claimant would have been entitled
7 in the absence of this article against the assets of
8 the impaired insurer. The expenses of the association
9 in handling claims shall be accorded the same priority
10 as the receiver's expenses.

11 Revisor's Note

12 Section 11(e), V.T.I.C. Article 9.48, refers to
13 the court "having jurisdiction." The revised law
14 omits the quoted language as unnecessary for the
15 reason stated in Revisor's Note (4) to Section
16 2602.003.

17 Revised Law

18 Sec. 2602.308. REPORT TO RECEIVER. The association shall
19 periodically file with the receiver of an impaired title insurance
20 company a statement of covered claims paid by the association and an
21 estimate of claims anticipated against the association. The
22 statement preserves the rights of the association against the
23 assets of the company. (V.T.I.C. Art. 9.48, Sec. 11(f).)

24 Source Law

25 (f) The association shall file periodically
26 with the receiver of the impaired insurer statements
27 of the covered claims paid by the association and
28 estimates of anticipated claims on the association
29 that shall preserve the rights of the association
30 against the assets of the impaired insurer.

31 [Sections 2602.309-2602.350 reserved for expansion]

32 SUBCHAPTER H. CONSERVATOR OR RECEIVER POWERS AND
33 DUTIES RELATING TO COVERED CLAIMS

34 Revised Law

35 Sec. 2602.351. DETERMINATION OF CONSERVATOR CONCERNING
36 REINSURANCE, ASSUMPTION, OR SUBSTITUTION. A conservator appointed
37 to handle the affairs of an impaired title insurance company or
38 agent shall determine whether covered claims should or can be
39 provided for in whole or in part by reinsurance, assumption, or
40 substitution. (V.T.I.C. Art. 9.48, Sec. 11(b) (part).)

1 Source Law

2 (b) If a conservator is appointed to handle the
3 affairs of an impaired insurer or agent, the
4 conservator shall determine whether or not covered
5 claims should or can be provided for in whole or in
6 part by reinsurance, assumption, or
7 substitution. . . .

8 Revised Law

9 Sec. 2602.352. NOTICE OF DETERMINATION CONCERNING ACTUAL
10 PAYMENT. (a) On determination by the conservator that covered
11 claims should be actually paid, the conservator shall give notice
12 of the determination to holders of covered claims.

13 (b) The conservator shall mail the notice to each holder of
14 a covered claim at the most recent address shown in the impaired
15 title insurance company's or agent's records, except that if those
16 records do not show the claimant's address the conservator may give
17 notice by publication in a newspaper of general circulation.

18 (c) The notice must state a date, not earlier than the 91st
19 day after the date of the mailing or publication of the notice,
20 before which the claimant must file a claim with the conservator.
21 (V.T.I.C. Art. 9.48, Sec. 11(b) (part).)

22 Source Law

23 (b) . . . Upon determination by the
24 conservator that actual payment of covered claims
25 should be made, the conservator shall give notice of
26 such determination to claimants falling within the
27 class of "covered claims." The conservator shall mail
28 such notice to the latest address reflected in the
29 records of the impaired insurer or agent. If the
30 records of the impaired insurer or agent do not reflect
31 the address of a claimant, the conservator may give
32 notice by publication in a newspaper of general
33 circulation. Such notice shall state the time within
34 which the claimant must file his claim with the
35 conservator, which time shall in no event be less than
36 90 days from the date of the mailing or publication of
37 such notice. . . .

38 Revised Law

39 Sec. 2602.353. FILING OF COVERED CLAIM. The conservator
40 may require in whole or in part that claimants file:

- 41 (1) sworn claim forms; and
42 (2) additional information or evidence reasonably
43 necessary for the conservator to determine the legality of or
44 amount due under a covered claim. (V.T.I.C. Art. 9.48, Sec. 11(b))

1 (part).)

2 Source Law

3 (b) . . . The conservator may require, in
4 whole or in part, that sworn claim forms be filed and
5 may require that additional information or evidence be
6 filed as may be reasonably necessary for the
7 conservator to determine the legality or the amount
8 due under a covered claim. . . .

9 Revised Law

10 Sec. 2602.354. CLAIM BY PERSON WITH CAUSE OF ACTION AGAINST
11 INSURED. (a) On determination by the conservator that covered
12 claims should be actually paid or on order of the court to the
13 receiver to give notice for the filing of claims, a person having a
14 cause of action that constitutes a covered claim against an insured
15 of the impaired title insurance company under a title insurance
16 policy issued or assumed by the company may file the claim with the
17 receiver or conservator, regardless of whether the claim is
18 unliquidated or undetermined.

19 (b) A claim under this section may be approved as a covered
20 claim if:

21 (1) it may be reasonably inferred from the proof
22 presented that the claimant would be able to obtain a judgment on
23 the cause of action against the insured;

24 (2) the claimant provides suitable proof that no valid
25 claim exists against the impaired title insurance company arising
26 from the cause of action other than claims already made; and

27 (3) the total liability of the impaired title
28 insurance company to all claimants under the same title insurance
29 policy does not exceed the amount of the company's total liability
30 if the company were not in liquidation, rehabilitation, or
31 conservation. (V.T.I.C. Art. 9.48, Sec. 11(c) (part).)

32 Source Law

33 (c) Upon determination by the conservator that
34 actual payment of covered claims should be made or upon
35 order of the court to the receiver to give notice for
36 the filing of claims, any person who has a cause of
37 action against an insured of the impaired insurer
38 under a title insurance policy issued or assumed by
39 such insurer shall, if such cause of action meets the
40 definition of "covered claim," have the right to file a

1 claim with the receiver or the conservator, regardless
2 of the fact that such claim may be unliquidated or
3 undetermined, and such claim may be approved as a
4 "covered claim" (1) if it may be reasonably inferred
5 from the proof presented upon such claim that such
6 person would be able to obtain a judgment upon such
7 cause of action against such insured; and (2) if such
8 person shall furnish suitable proof that no further
9 valid claims against such insurer arising out of his
10 cause of action other than those already presented can
11 be made; and (3) if the total liability of such insurer
12 to all claimants arising from the same title insurance
13 policy shall be no greater than its total liability
14 would be were it not in liquidation, rehabilitation,
15 or conservation. . . .

16 Revised Law

17 Sec. 2602.355. REPORT TO ASSOCIATION. (a) A receiver of
18 an impaired title insurance company or agent shall periodically
19 submit a list of claims to the association or a similar organization
20 in another state.

21 (b) Notice of a claim to the receiver is considered notice
22 to the association. (V.T.I.C. Art. 9.48, Sec. 10(g) (part).)

23 Source Law

24 (g) . . . Notice of claims to the receiver of
25 the impaired insurer or agent shall constitute notice
26 to the association or its agent and a list of claims
27 periodically shall be submitted to the association or
28 similar organization in another state by the receiver.

29 Revisor's Note

30 Section 10(g), V.T.I.C. Article 9.48, provides
31 that notice of claims to a receiver constitutes notice
32 to "the association or its agent." The revised law
33 omits the quoted reference to "its agent" to avoid
34 confusion with the different meaning of "agent"
35 provided by the law revised in this chapter and because
36 under principles of agency law notice to a principal
37 (the association) and the principal's agent are
38 equivalent.

39 [Sections 2602.356-2602.400 reserved for expansion]

40 SUBCHAPTER I. OPERATION OF IMPAIRED TITLE INSURANCE
41 COMPANY OR AGENT

42 Revised Law

43 Sec. 2602.401. ISSUANCE OR RENEWAL OF POLICIES. (a) If an

1 assessment has been made under this chapter for an impaired title
2 insurance company or association funds have been provided for the
3 company, the company, on release from the conservatorship or
4 receivership, may not issue a new or renewal insurance policy until
5 the company:

6 (1) has repaid pro rata in full to each holder of a
7 participation receipt the assessment amount paid by the receipt
8 holder or its assignee; and

9 (2) has repaid in full the amount of guaranty fees paid
10 by the association.

11 (b) If an assessment has been made under this chapter for an
12 impaired agent or guaranty fees have been provided for the agent,
13 the agent, on release from the conservatorship or receivership, may
14 not issue a new or renewal insurance policy until the agent has
15 repaid in full the amount of guaranty fees paid by the association.

16 (c) Notwithstanding Subsections (a) and (b), on application
17 of the association and after hearing, the commissioner may permit
18 the impaired title insurance company or agent to issue new policies
19 as provided by a plan of operation for repayment. In approving the
20 plan, the commissioner may restrict the issuance of new or renewal
21 policies as the commissioner considers necessary to implement the
22 plan.

23 (d) Not later than the 11th day before the date of a hearing
24 under Subsection (c), the commissioner shall give notice of the
25 hearing to the association. The commissioner shall give 10 days'
26 notice of the hearing to title insurance companies to whom
27 participation receipts were issued for an assessment made for the
28 benefit of the released title insurance company. The association
29 and title insurance companies are entitled to appear at and
30 participate in the hearing.

31 (e) Money recovered against an impaired title insurance
32 company under this section shall be repaid to the title insurance
33 companies that paid assessments in relation to the impaired title
34 insurance company on return of the participation receipt.

1 (V.T.I.C. Art. 9.48, Secs. 13, 23(i).)

2 Source Law

3 Sec. 13. An impaired insurer or agent placed in
4 conservatorship or receivership for which assessments
5 have been made under the provisions of this article, or
6 for which guaranty fees have been provided, shall not
7 be authorized, upon release from conservatorship or
8 receivership, to issue new or renewal insurance
9 policies until such time as the impaired insurer has
10 repaid pro rata in full to each holder of a
11 participation receipt the assessment amount paid by
12 the receipt holder or its assigns or the impaired agent
13 has repaid in full the amount of guaranty fees
14 furnished by the association; provided, however, the
15 commissioner may, upon application of the association
16 and after hearing, permit the issuance of new policies
17 in accordance with a plan of operations by the released
18 insurer or agent for repayment. The commissioner may,
19 in approving such plan, place such restrictions upon
20 the issuance of new or renewal policies as he deems
21 necessary to the implementation of the plan. The
22 commissioner shall give 10 days notice of such hearing
23 to the insurers to whom the participation receipts
24 were issued for an assessment made for the benefit of
25 the released insurer and the association, and the
26 holders of the receipts and the association shall be
27 entitled to appear at and participate in such hearing.

28 [Sec. 23]

29 (i) An impaired insurer placed in
30 conservatorship or receivership for which assessments
31 have been made under this article, or for which
32 association funds have been provided, may not, on
33 release from conservatorship or receivership, issue
34 new or renewal insurance policies until the insurer
35 has repaid in full the amount of guaranty fees
36 furnished by the association. The commissioner may
37 permit, on application of the association and after
38 hearing, the issuance of new policies in accordance
39 with a plan of operation by the released insurer for
40 repayment. The commissioner, in approving the plan,
41 may place restrictions on the issuance of new or
42 renewal policies as necessary for the implementation
43 of the plan. The commissioner shall give notice of a
44 hearing under this subsection to the association not
45 later than the 11th day before the date on which the
46 hearing is scheduled. The association and member
47 insurers that paid assessments in relation to the
48 impaired insurer are entitled to appear at and
49 participate in the hearing. Money recovered by the
50 association under this subsection shall be repaid to
51 the member insurers that paid assessments in relation
52 to the impaired insurer on return of the appropriate
53 certificate of contribution.

54 Revisor's Note

55 (1) Sections 13 and 23(i), V.T.I.C. Article
56 9.48, refer to an impaired title insurance company or
57 agent "placed in conservatorship or receivership."
58 The revised law omits the quoted language because the

1 definitions of "impaired [title] insurance company"
2 and "impaired agent" provided by Sections 5(4) and
3 (8), V.T.I.C. Article 9.48, revised as Sections
4 2602.003(5) and (6), provide that to be an impaired
5 title insurance company or impaired agent the company
6 or agent must have been placed in conservatorship or
7 receivership.

8 (2) Section 13, V.T.I.C. Article 9.48, refers to
9 an impaired title insurance company or agent for which
10 "guaranty fees" have been provided. Section 23(i),
11 V.T.I.C. Article 9.48, in the same context refers to an
12 impaired title insurance company for which
13 "association funds" have been provided. The revised
14 law uses the phrase "association funds" because
15 guaranty fees are a type of association funds. See
16 also the discussion in Revisor's Note (3) to this
17 section regarding the relative dates of enactment of
18 Sections 13 and 23(i).

19 (3) Section 13, V.T.I.C. Article 9.48, requires
20 that certain title insurance companies and the
21 association be given "10 days notice" of a hearing
22 under that section. Section 23(i), V.T.I.C. Article
23 9.48, requires that the association be given this
24 notice "not later than the 11th day before the date" of
25 the hearing. Although for all practical purposes the
26 quoted provisions mean the same thing, a technical
27 analysis of the provisions could find them to be
28 different. Because only Section 13 addresses the
29 notice required to be given to the title insurance
30 companies, the revised law uses that provision to
31 describe the notice to be given to the title insurance
32 companies. However, the provisions irreconcilably
33 conflict with respect to the notice required to be
34 given to the association. Section 311.025, Government

1 Code (Code Construction Act), provides that if
2 statutes are irreconcilable the latest in date of
3 enactment prevails. The pertinent provision of
4 Section 13 was enacted by Section 1, Chapter 1073, Acts
5 of the 70th Legislature, Regular Session, 1987.
6 Section 23 was enacted by Section 11.11, Chapter 685,
7 Acts of the 73rd Legislature, Regular Session, 1993.
8 Therefore, with respect to the notice required to be
9 given to the association, the revised law uses the
10 Section 23 provision, which was the later enacted.

11 (4) Section 23(i), V.T.I.C. Article 9.48,
12 refers to "the appropriate certificate of
13 contribution." The revised law substitutes
14 "participation receipt" for the quoted language
15 because "participation receipt" is the term used in
16 this chapter to refer to that certificate.

17 Revised Law

18 Sec. 2602.402. DISTRIBUTIONS TO SHAREHOLDERS AND
19 AFFILIATES. (a) An impaired or insolvent title insurance company
20 may not make a distribution to shareholders until the association
21 has recovered the total amount of valid claims for money spent in
22 exercising the association's powers and performing the
23 association's duties under this chapter with respect to that
24 company, plus interest on that amount.

25 (b) Except as otherwise provided by this section, the
26 receiver appointed under an order of receivership of a title
27 insurance company domiciled in this state may recover on behalf of
28 the company from an affiliate that controlled the company the
29 amount of a distribution, other than a stock dividend the company
30 paid on its common stock, made during the five years preceding the
31 date of the petition for liquidation or rehabilitation.

32 (c) A person who was an affiliate that controlled the title
33 insurance company when the distribution described by Subsection (b)
34 was paid is liable for the amount of the distribution received. A

1 person who was an affiliate that controlled the title insurance
2 company when the distribution was declared is liable for the amount
3 of the distribution the affiliate would have received if the
4 distribution had been paid immediately. Two or more persons liable
5 for the same distribution are jointly and severally liable. If a
6 person liable under this subsection is insolvent, all of the
7 affiliates that controlled the insolvent person when the
8 distribution was paid are jointly and severally liable for any
9 resulting deficiency in the amount recovered from the insolvent
10 person.

11 (d) The maximum amount recoverable under Subsections (b)
12 and (c) is the amount needed in excess of all other available assets
13 of the insolvent title insurance company to pay the company's
14 contractual obligations.

15 (e) The receiver may not recover a distribution under
16 Subsection (b) if the title insurance company shows that:

17 (1) the distribution was lawful and reasonable on the
18 date of payment; and

19 (2) the company did not know and could not reasonably
20 have known that the distribution might adversely affect the ability
21 of the company to fulfill its contractual obligations. (V.T.I.C.
22 Art. 9.48, Secs. 23(c), (d), (e), (f), (g), (h).)

23 Source Law

24 (c) A distribution to stockholders of an
25 impaired or insolvent insurer may not be made until the
26 total amount of valid claims of the association for
27 funds expended in carrying out its powers and duties
28 under this article with respect to the insurer have
29 been recovered with interest by the association.

30 (d) If an order of receivership of an insurer
31 domiciled in this state has been entered, the receiver
32 appointed under the order may recover on behalf of the
33 insurer, from any affiliate that controlled it, the
34 amount of distributions, other than stock dividends
35 paid by the insurer on its capital stock, made at any
36 time during the five years preceding the petition for
37 liquidation or rehabilitation, subject to the
38 limitations imposed under Subsections (e), (f), and
39 (g) of this section.

40 (e) A distribution to stockholders is not
41 recoverable under Subsection (d) of this section if
42 the insurer shows that the distribution was lawful and
43 reasonable as of the date of payment, and that the
44 insurer did not know and could not reasonably have

1 known that the distribution might adversely affect the
2 ability of the insurer to fulfill its contractual
3 obligations.

4 (f) A person that was an affiliate that
5 controlled the insurer at the time distributions
6 subject to Subsection (d) of this section were paid is
7 liable for the amount of distributions received. A
8 person that was an affiliate that controlled the
9 insurer at the time the distributions were declared is
10 liable for the amount of distributions the person
11 would have received if they had been paid immediately.
12 If two or more persons are liable with respect to the
13 same distributions, those persons are jointly and
14 severally liable.

15 (g) The maximum amount recoverable under
16 Subsections (d) and (f) of this section is the amount
17 needed in excess of all other available assets of the
18 insolvent insurer to pay the contractual obligations
19 of the insolvent insurer.

20 (h) If a person liable under Subsection (f) of
21 this section is insolvent, all of its affiliates that
22 controlled it at the time the distribution was paid are
23 jointly and severally liable for any resulting
24 deficiency in the amount recovered from the insolvent
25 affiliate.

26 Revised Law

27 Sec. 2602.403. ASSETS ATTRIBUTABLE TO COVERED
28 POLICIES. (a) For the purposes of this section, assets
29 attributable to covered policies are the proportion of the assets
30 that the reserves that should have been established for the covered
31 policies bear to the reserves that should have been established for
32 all insurance policies written by the impaired or insolvent title
33 insurance company.

34 (b) To perform its obligations under this chapter, the
35 association is considered a creditor of the impaired or insolvent
36 title insurance company to the extent of assets attributable to
37 covered policies, less any amount that the association recovers as
38 a subrogee under this chapter.

39 (c) Assets of the impaired or insolvent title insurance
40 company attributable to covered policies shall be used to continue
41 all covered policies and pay all contractual obligations of the
42 impaired or insolvent company as required by this chapter.

43 (V.T.I.C. Art. 9.48, Sec. 23(b).)

44 Source Law

45 (b) To carry out its obligations under this
46 article, the association is considered a creditor of
47 the impaired or insolvent insurer to the extent of
48 assets attributable to covered policies, reduced by

1 any amounts that the association recovers as a
2 subrogee under this article. Assets of the impaired or
3 insolvent insurer attributable to covered policies
4 shall be used to continue all covered policies and pay
5 all contractual obligations of the impaired or
6 insolvent insurer as required by this article. For
7 purposes of this subsection, assets attributable to
8 covered policies are that proportion of the assets
9 that the reserves that should have been established
10 for the covered policies bear to the reserves that
11 should have been established for all policies of
12 insurance written by the impaired or insolvent
13 insurer.

14 Revisor's Note
15 (End of Chapter)

16 Section 22, V.T.I.C. Article 9.48, provides that
17 the article does not apply to a person if the
18 constitution of this state or the United States
19 prohibits the application. The revision omits this
20 section as unnecessary because by the nature of
21 constitutional government the constitutions of this
22 state and the United States prevail over a statute.
23 The omitted law reads:

24 Sec. 22. This article and law does
25 not apply to any insurer or other person to
26 whom, under the Constitution of the United
27 States or the Constitution of the State of
28 Texas, it cannot validly apply.

29 [Chapters 2603-2650 reserved for expansion]

30 SUBTITLE D. TITLE INSURANCE PROFESSIONALS

31 CHAPTER 2651. TITLE INSURANCE AGENTS AND DIRECT OPERATIONS

32 SUBCHAPTER A. TITLE INSURANCE AGENT'S LICENSE

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39 Sec. 2651.007. LICENSE RENEWAL 1601
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1 [Sections 2651.012-2651.050 reserved for expansion]

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7 SUBCHAPTER F. TITLE INSURANCE COMPANY POWERS

8 AND DUTIES

9 REGARDING TITLE INSURANCE AGENTS

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20 CHAPTER 2651. TITLE INSURANCE AGENTS AND DIRECT OPERATIONS

21 SUBCHAPTER A. TITLE INSURANCE AGENT'S LICENSE

22 Revised Law

23 Sec. 2651.001. LICENSE AND BOND OR DEPOSIT

24 REQUIRED. (a) An individual, firm, association, or corporation

25 may not act in this state as a title insurance agent for a title

26 insurance company unless the individual or entity:

27 (1) holds a license as an agent issued by the

28 department; and

29 (2) maintains a surety bond or deposit required under

30 Subchapter C.

31 (b) A title insurance company may not allow or permit an

32 individual, firm, association, or corporation to act as its agent

33 in this state unless the individual or entity complies with this

34 section. (V.T.I.C. Art. 9.35.)

1 initial license is issued to an individual, firm, association, or
2 corporation to act as an agent in this state for a title insurance
3 company, the company must file an application for an agent's
4 license with the department on forms provided by the department.

5 (b) The application must be:

6 (1) accompanied by a nonrefundable license fee; and

7 (2) signed and sworn to by the title insurance company
8 and by the proposed agent.

9 (c) The completed application must state that:

10 (1) the proposed agent is:

11 (A) an individual who is a bona fide resident of
12 this state;

13 (B) an association or firm composed only of Texas
14 residents; or

15 (C) a Texas corporation or a foreign corporation
16 authorized to engage in business in this state;

17 (2) the proposed agent, including a corporation's
18 managerial personnel, if applicable, has reasonable experience or
19 instruction in the field of title insurance;

20 (3) the title insurance company:

21 (A) knows that the proposed agent has a good
22 business reputation and is worthy of the public trust; and

23 (B) is unaware of any fact or condition that
24 disqualifies the proposed agent from receiving a license; and

25 (4) the proposed agent qualifies as a title insurance
26 agent under this chapter. (V.T.I.C. Art. 9.36, Sec. 1(a) (part).)

27 Source Law

28 Art. 9.36

29 Sec. 1. (a) Before an initial license is
30 issued to any person, firm, association or corporation
31 to act as an agent within the State of Texas for any
32 title insurance company, there shall first be filed by
33 the title insurance company with the Board an
34 application for agent's license, on forms to be
35 provided by the Board, accompanied by a nonrefundable
36 license fee The application shall be signed
37 and duly sworn to by the title insurance company and
38 the proposed agent. Such application shall contain
39 the following:

40 (1) That the proposed agent, if an

1 individual, is a bona fide resident of Texas; or if a
2 firm or association, that it is composed wholly of
3 Texas residents; or if a corporation, that it is a
4 Texas corporation or a foreign corporation which has
5 been authorized to do business in Texas; and

6 (2) That the proposed agent (and if a
7 corporation, its managerial personnel) has reasonable
8 experience or instruction in the field of title
9 insurance; and

10 (3) That the proposed agent is known to the
11 title insurance company to have a good business
12 reputation and is worthy of the public trust and said
13 title insurance company knows of no fact or condition
14 which would disqualify the agent from receiving a
15 license; and

16 (4) That the proposed agent qualified as a
17 title insurance agent as defined in this Act.

18 Revised Law

19 Sec. 2651.003. LICENSE AND RENEWAL FEES. (a) The
20 department shall prescribe the license fee in an amount not to
21 exceed \$50.

22 (b) License fees, and renewal fees collected under this
23 subchapter, shall be deposited to the credit of the Texas
24 Department of Insurance operating account to be used by the
25 department to enforce this chapter and any other law of this state
26 that regulates title insurance agents. (V.T.I.C. Art. 9.36, Sec.
27 1(a) (part).)

28 Source Law

29 (a) . . . [license fee] in an amount not to
30 exceed Fifty Dollars (\$50) as determined by the Board,
31 which fee including license renewal fees shall be
32 deposited in the state treasury to the credit of the
33 State Board of Insurance operating fund to be used by
34 the State Board of Insurance to enforce the provisions
35 of this article and all laws of this state governing
36 and regulating title agents for such insurance
37 companies. . . .

38 Revisor's Note

39 Section 1(a), V.T.I.C. Article 9.36, requires
40 license and renewal fees to be deposited in the state
41 treasury to the credit of the State Board of Insurance
42 operating fund. Under the authority of Chapter 4, Acts
43 of the 72nd Legislature, 1st Called Session, 1991, the
44 Texas Department of Insurance operating fund (the
45 later name of the State Board of Insurance operating
46 fund) was converted to an account in the general

1 revenue fund. Throughout this chapter, the revised
2 law is drafted accordingly.

3 Revised Law

4 Sec. 2651.004. LICENSE ISSUANCE. The department shall
5 issue a license if the department determines, based on the
6 application and the department's investigation, that the
7 requirements of Section 2651.002 are satisfied. (V.T.I.C.
8 Art. 9.36, Sec. 1(b).)

9 Source Law

10 (b) The Board shall grant such license if it
11 determines from the application and its own
12 investigation that the foregoing requirements have
13 been met.

14 Revised Law

15 Sec. 2651.005. DUPLICATE LICENSE. (a) The department
16 shall collect in advance a fee from a title insurance agent who
17 requests a duplicate license.

18 (b) The department shall prescribe the fee in an amount not
19 to exceed \$20. (V.T.I.C. Art. 9.36, Sec. 1(c).)

20 Source Law

21 (c) The Commissioner shall collect in advance
22 from agents requesting duplicate licenses a fee not to
23 exceed \$20. The State Board of Insurance shall
24 determine the amount of the fee.

25 Revised Law

26 Sec. 2651.006. LICENSE TERM. Unless a system of staggered
27 license renewal is adopted under Section 4003.002, a license issued
28 under this subchapter expires on June 1 after the second
29 anniversary of the date of issuance. (V.T.I.C. Art. 9.36, Sec.
30 2(b).)

31 Source Law

32 (b) Unless a staggered renewal system is adopted
33 under Article 21.01-2 of this code and its subsequent
34 amendments, a license shall continue in force until
35 June 1 after the second anniversary of the date on
36 which the license was issued unless previously
37 cancelled.

38 Revisor's Note

39 (1) Section 2(b), V.T.I.C. Article 9.36, refers

1 to Article 21.01-2 and "its subsequent amendments."
2 The revised law omits "its subsequent amendments" in
3 this section and throughout this chapter because under
4 Section 311.027, Government Code (Code Construction
5 Act), unless expressly provided otherwise, a reference
6 to a statute applies to all reenactments, revisions,
7 or amendments of the statute.

8 (2) Section 2(b), V.T.I.C. Article 9.36,
9 provides that an agent's license expires on a certain
10 date "unless previously cancelled." The revised law
11 omits the quoted language as unnecessary because
12 cancellation of the license would cause the license to
13 no longer be valid, and thus the expiration date would
14 be rendered meaningless because of the nature of
15 cancellation and not because of the omitted statutory
16 provision.

17 Revised Law

18 Sec. 2651.007. LICENSE RENEWAL. (a) A title insurance
19 agent may renew a license by:

20 (1) filing a completed license renewal application
21 form with the department; and

22 (2) paying the nonrefundable license renewal fee to
23 the department.

24 (b) The department shall prescribe the license renewal
25 application form.

26 (c) The department shall prescribe the license renewal fee
27 in an amount not to exceed \$50. (V.T.I.C. Art. 9.36, Sec. 2(a).)

28 Source Law

29 Sec. 2. (a) To renew a license, an agent shall
30 file a completed application for renewal on a form
31 prescribed by the Board and pay a nonrefundable
32 license renewal fee in an amount not to exceed \$50 as
33 determined by the Board.

34 Revised Law

35 Sec. 2651.008. RECORDS OF AGENTS. The department shall
36 maintain a record of the name and address of each title insurance

1 agent licensed by the department in a manner that ensures that the
2 agents appointed by any company authorized to engage in the
3 business of title insurance in this state may be conveniently
4 ascertained and inspected by any person on request. (V.T.I.C.
5 Art. 9.36, Sec. 2(c).)

6 Source Law

7 (c) The Board shall keep a record of the names
8 and addresses of all licensed agents in such manner
9 that the agents appointed by any company authorized to
10 transact title insurance business within the State of
11 Texas may be conveniently ascertained and inspected by
12 any person upon request.

13 Revised Law

14 Sec. 2651.009. MULTIPLE APPOINTMENTS. (a) A licensed
15 title insurance agent may be appointed to represent additional
16 title insurance companies.

17 (b) Any additional title insurance company must notify the
18 department of the appointment in the manner prescribed by the
19 department. The agent must include with the notice a nonrefundable
20 fee for each additional appointment. The department shall
21 prescribe the fee in an amount not to exceed \$16.

22 (c) The appointment is effective on the eighth day following
23 the date the department receives the completed notice of
24 appointment and the fee, unless the department rejects the
25 appointment. If the department rejects the appointment, the
26 department shall state in writing the reasons for rejection not
27 later than the seventh day after the date on which the department
28 receives the completed notice of appointment.

29 (d) A title insurance company may not permit an agent
30 appointed by the company to write, sign, or deliver title insurance
31 until the agent's appointment is effective.

32 (e) The appointment remains effective, without the
33 necessity of renewal, until the appointment:

34 (1) is terminated by the title insurance company as
35 provided by this section; or

36 (2) is otherwise terminated under this subchapter.

1 (f) A renewal license issued to an agent authorizes the
2 agent to represent and act for the title insurance companies for
3 which the agent holds appointments until the appointments are
4 terminated, and the agent is considered to be the agent of the
5 appointing companies for purposes of this subchapter.

6 (g) When a title insurance company terminates the
7 appointment of an agent, the company shall immediately file with
8 the department a statement that contains:

9 (1) the facts relating to the termination of the
10 appointment; and

11 (2) the effective date and reason for the termination.

12 (h) On receipt of the statement, the department shall
13 terminate the appointment of the agent to represent that title
14 insurance company in this state. (V.T.I.C. Art. 9.36, Secs. 3(a),
15 (b), (c).)

16 Source Law

17 Sec. 3. (a) A licensed title insurance agent
18 may be appointed to represent additional title
19 insurance companies. Each additional company must
20 notify the Board of the appointment in the manner
21 prescribed by the Board. The agent shall pay a
22 nonrefundable fee for each additional appointment set
23 by the Board in an amount not to exceed \$16. The fee
24 must accompany the notice. A title insurance company
25 may not permit an agent appointed by the company to
26 write, sign, or deliver title insurance until the
27 agent has complied with this subsection. The agent
28 shall be deemed appointed for the additional title
29 insurance company on the eighth day following the date
30 the Board receives the completed notice of appointment
31 and the nonrefundable fee unless the Board rejects the
32 appointment for reasons stated in writing not later
33 than the seventh day after the date on which the Board
34 receives the notice of appointment.

35 (b) An appointment made under Subsection (a) of
36 this section continues in effect without the necessity
37 of renewal until it is terminated and withdrawn by the
38 title insurance company as provided by Subsection (c)
39 of this section or is otherwise terminated in
40 accordance with this article. Each renewal license
41 issued to the agent authorizes the agent to represent
42 and act for the title insurance companies for which the
43 agent holds an appointment until the appointment is
44 terminated, and that agent is considered to be the
45 agent of the appointing title insurance companies for
46 the purposes of this article.

47 (c) On the termination of the appointment of an
48 agent of a title insurance company, the company
49 immediately shall file with the State Board of
50 Insurance a statement of the facts relating to the
51 termination of the appointment and the effective date

1 and cause of the termination. The Board shall
2 terminate the appointment of the agent to represent
3 that insurance company in this state on receipt of the
4 statement.

5 Revisor's Note

6 Section 3(b), V.T.I.C. Article 9.36, refers to an
7 appointment that continues until it is "terminated and
8 withdrawn." The revised law omits "withdrawn" because
9 its meaning is included in the meaning of
10 "terminated."

11 Revised Law

12 Sec. 2651.010. SUSPENSION OF LICENSE. The department
13 shall suspend the license of a title insurance agent during any
14 period in which the agent does not have a valid appointment. The
15 department shall end the suspension when the department receives an
16 acceptable notice of a valid appointment. (V.T.I.C. Art. 9.36,
17 Sec. 4.)

18 Source Law

19 Sec. 4. The Board shall suspend the license of a
20 title insurance agent during any period in which the
21 agent does not have an outstanding valid appointment.
22 The Board shall end the suspension on receipt of
23 acceptable notice of a valid appointment.

24 Revisor's Note

25 Section 4, V.T.I.C. Article 9.36, refers to an
26 "outstanding valid appointment." The revised law
27 omits "outstanding" as unnecessary because, in this
28 context, the meaning of "outstanding" is included in
29 the meaning of "valid."

30 Revised Law

31 Sec. 2651.011. PRIVILEGED COMMUNICATIONS. Any
32 information, including a document, record, or statement, required
33 to be made or disclosed to the department under this subchapter,
34 other than Section 2651.001, is:

- 35 (1) a privileged communication; and
36 (2) not admissible in evidence in a court action or
37 proceeding except under a subpoena issued by a court of record.
38 (V.T.I.C. Art. 9.36, Sec. 3(d).)

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Source Law

(d) Any information, document, record, or statement required to be made or disclosed to the Board under this article is a privileged communication, and is not admissible in evidence in any court action or proceeding except under a subpoena issued by a court of record.

Revisor's Note

Section 3(d), V.T.I.C. Article 9.36, refers to disclosures made to the board "under this article." The revised law substitutes "subchapter" for "article" because Article 9.36 is revised only in this subchapter. The only provision revised in this subchapter not derived from Article 9.36 is Section 2651.001, and the revised law accordingly excludes Section 2651.001 from the scope of this section.

[Sections 2651.012-2651.050 reserved for expansion]

SUBCHAPTER B. DIRECT OPERATION LICENSE

Revised Law

Sec. 2651.051. LICENSE REQUIRED. (a) A title insurance company may not own or lease and operate an abstract plant or participate in a bona fide joint abstract plant operation in a county in this state unless the company holds a license as a direct operation issued by the department for that county.

(b) A title insurance company may not write, sign, or deliver title insurance in a county in which the company operates an abstract plant until the department has issued a direct operation license to the company. (V.T.I.C. Art. 9.36A, Secs. A, C (part).)

Source Law

Art. 9.36A. A. A title insurance company owning or leasing and operating an abstract plant or participating in a bona fide joint abstract plant operation in any county in this state must be licensed by the Board for that county.

C. . . . A title insurance company may not write, sign, or deliver title insurance in any county in which it operates an abstract plant until the Board has issued a license. . . .

Revised Law

Sec. 2651.052. LICENSE APPLICATION. (a) Before a direct

1 operation license is issued to a title insurance company, the
2 company must file an application for a direct operation license on
3 forms provided by the department.

4 (b) The application must be:

5 (1) accompanied by a nonrefundable license fee; and

6 (2) signed and sworn to by the title insurance
7 company.

8 (c) The completed application must state that:

9 (1) the title insurance company is a Texas corporation
10 or a foreign corporation holding a certificate of authority to
11 insure titles to real property in this state and meets the
12 requirements of this title; and

13 (2) the abstract plant to be licensed:

14 (A) complies with department requirements
15 relating to abstract plants; and

16 (B) has been approved by the department.

17 (V.T.I.C. Art. 9.36A, Sec. B (part).)

18 Source Law

19 B. Before a license for a county is issued, an
20 application must be filed for a direct operation
21 license, on forms to be provided by the Board,
22 accompanied by a nonrefundable license fee

23 The application shall be signed and duly sworn to
24 by the title insurance company. The applicant must
25 comply with and must include in the application the
26 following:

27 (1) that the title insurance company is a
28 Texas corporation or a foreign corporation holding a
29 certificate of authority to insure titles to real
30 estate within this state and meets the requirements of
31 this chapter; and

32 (2) that the abstract plant to be licensed
33 complies with requirements made by the Board
34 pertaining to abstract plants and has been approved by
35 the Board.

36 Revised Law

37 Sec. 2651.053. LICENSE AND RENEWAL FEES. (a) The
38 department shall prescribe the license fee in an amount not to
39 exceed \$50.

40 (b) License fees, and renewal fees collected under this
41 subchapter, shall be deposited to the credit of the Texas
42 Department of Insurance operating account to be used by the

1 department to enforce this chapter and the laws of this state that
2 regulate title insurance agents and title insurance companies.
3 (V.T.I.C. Art. 9.36A, Sec. B (part).)

4 Source Law

5 B. . . . [license fee] in an amount not to
6 exceed \$50 as determined by the Board. The license fee
7 and renewal fees shall be deposited in the state
8 treasury to the credit of the State Board of Insurance
9 operating fund to be used by the Board to enforce this
10 Article and all laws of this state governing and
11 regulating title insurance agents and title insurance
12 companies. . . .

13 Revised Law

14 Sec. 2651.054. LICENSE TERM. Unless a system of staggered
15 license renewal is adopted, a license issued under this subchapter
16 expires on the second June 1 following the date of issuance.
17 (V.T.I.C. Art. 9.36A, Sec. C (part).)

18 Source Law

19 C. . . .
20 Unless a staggered renewal system is adopted, a
21 license continues in force until the second June 1
22 after its issuance, unless previously cancelled. . . .

23 Revisor's Note

24 Section C, V.T.I.C. Article 9.36A, provides that
25 a direct operation license expires on a certain date
26 "unless previously cancelled." The revised law omits
27 the quoted language as unnecessary for the reasons
28 stated in Revisor's Note (2) to Section 2651.006.

29 Revised Law

30 Sec. 2651.055. LICENSE RENEWAL. (a) On or before the
31 expiration date of a license issued under this subchapter, a title
32 insurance company may renew the license by:

33 (1) certifying to the department each county and
34 address at which the company operates the abstract plant for each
35 license to be renewed;

36 (2) filing a completed renewal application; and

37 (3) paying a nonrefundable license renewal fee for
38 each license.

39 (b) The department shall provide the forms used under this

1 section.

2 (c) The department shall prescribe the license renewal fee
3 in an amount not to exceed \$50.

4 (d) If a license has been expired for 90 days or less, the
5 license holder may renew the license by paying to the department the
6 required nonrefundable renewal fee and a nonrefundable fee equal to
7 one-half of the original license fee.

8 (e) If a license has been expired for more than 90 days, the
9 license may not be renewed. (V.T.I.C. Art. 9.36A, Sec. C (part).)

10 Source Law

11 C. Each foreign or domestic title insurance
12 company operating under this Article shall certify to
13 the Board on or before the expiration date of the
14 company's license or licenses, on forms provided by the
15 Board, the counties and addresses of each location
16 within the state at which the title insurance company
17 operates an abstract plant for which a license is to be
18 renewed and shall file a completed renewal application
19 and pay a nonrefundable license renewal fee in an
20 amount not to exceed \$50, as determined by the Board,
21 for a license in each county. If a license has been
22 expired for not longer than 90 days, the licensee may
23 renew the license by paying to the Board the required
24 nonrefundable renewal fee and a nonrefundable fee that
25 is one-half of the original license fee. If a license
26 has been expired for more than 90 days, the license may
27 not be renewed. . . .

28 Revisor's Note

29 Section C, V.T.I.C. Article 9.36A, refers to a
30 "foreign or domestic" title insurance company. The
31 revised law omits the quoted language for the reasons
32 stated in Revisor's Note (1) to Section 2651.001.

33 Revised Law

34 Sec. 2651.056. CEASING OPERATION OF ABSTRACT PLANT; REQUEST
35 FOR LICENSE CANCELLATION. If a title insurance company ceases to
36 operate a licensed abstract plant, the company shall immediately
37 notify the department in writing and request cancellation of the
38 license. (V.T.I.C. Art. 9.36A, Sec. C (part).)

39 Source Law

40 C. . . . If any company ceases to operate a
41 licensed abstract plant, it shall immediately notify
42 the Board in writing and request cancellation of the
43 license. . . .

1 Revised Law

2 Sec. 2651.057. AUTOMATIC TERMINATION OF LICENSES. If a
3 title insurance company surrenders the company's certificate of
4 authority or if the certificate of authority is revoked by the
5 department, all licenses of the company's abstract plants
6 automatically terminate. (V.T.I.C. Art. 9.36A, Sec. C (part).)

7 Source Law

8 C. . . .
9 . . . If a title insurance company surrenders or
10 has its certificate of authority revoked by the Board,
11 all existing licenses of its abstract plants
12 automatically terminate. . . .

13 Revised Law

14 Sec. 2651.058. RECORDS OF DIRECT OPERATIONS. The
15 department shall maintain a record of the county and address of each
16 location at which a title insurance company operates an abstract
17 plant in a manner that ensures that the abstract plants may be
18 conveniently ascertained and inspected by any person on request.
19 (V.T.I.C. Art. 9.36A, Sec. C (part).)

20 Source Law

21 C. . . .
22 The Board shall keep a record of the counties and
23 addresses of each location in which the title
24 insurance company operates an abstract plant in such a
25 manner that the plants may be conveniently ascertained
26 and inspected by any person on request.

27 Revised Law

28 Sec. 2651.059. USE OF AGENTS NOT PROHIBITED. This
29 subchapter does not prohibit a title insurance company from issuing
30 title insurance through a licensed title insurance agent.
31 (V.T.I.C. Art. 9.36A, Sec. C (part).)

32 Source Law

33 C. . . . This Article may not be construed to
34 prohibit the issuance of title insurance by a title
35 insurance company by and through a duly licensed title
36 insurance agent. . . .

37 [Sections 2651.060-2651.100 reserved for expansion]

38 SUBCHAPTER C. BOND AND DEPOSIT REQUIREMENTS

39 Revised Law

40 Sec. 2651.101. BOND REQUIRED. (a) Each licensed title

1 insurance agent and direct operation shall make, file, and pay for a
2 surety bond payable to the department and issued by a corporate
3 surety company authorized to write surety bonds in this state. The
4 bond shall obligate the principal and surety to pay for any
5 pecuniary loss sustained by:

6 (1) any participant in an insured real property
7 transaction through an act of fraud, dishonesty, theft,
8 embezzlement, or wilful misapplication by a title insurance agent
9 or direct operation; or

10 (2) the department as a result of any administrative
11 expense incurred in a receivership of a title insurance agent or
12 direct operation.

13 (b) The amount of the bond must be the greater of:

14 (1) \$10,000; or

15 (2) an amount equal to 10 percent of the gross premium
16 written by the title insurance agent or direct operation in
17 accordance with the latest statistical report to the department but
18 not to exceed \$100,000. (V.T.I.C. Art. 9.38, Sec. (a) (part).)

19 Source Law

20 Art. 9.38. (a) Every person, firm,
21 association, or corporation which has been licensed as
22 a title insurance agent or direct operation shall
23 make, file, and pay for a surety bond with a corporate
24 surety company authorized to write surety bonds in
25 this state, payable to the State Board of Insurance in
26 the sum of the greater of Ten Thousand Dollars
27 (\$10,000) or an amount equal to ten percent (10%) of
28 the gross premium written by the agent or direct
29 operation in accordance with the latest statistical
30 report to the Board, but not to exceed One Hundred
31 Thousand Dollars (\$100,000). The bond shall obligate
32 the principal and surety to pay such pecuniary losses
33 as may result to any participant in an insured real
34 estate transaction which shall be sustained through
35 acts of fraud, dishonesty, theft, embezzlement, or
36 wilful misapplication on the part of a title insurance
37 agent or direct operation, or which may result to the
38 Board due to administrative expenses incurred in a
39 receivership of a title insurance agent or direct
40 operation. . . .

41 Revised Law

42 Sec. 2651.102. ALTERNATIVE TO BOND. (a) Instead of the
43 bond required by Section 2651.101, a title insurance agent or
44 direct operation may deposit with the department:

- 1 (1) cash;
- 2 (2) irrevocable letters of credit issued by a
3 financial institution in this state that is insured by an agency of
4 the United States; or
- 5 (3) securities approved by the department.

6 (b) The cash, letters of credit, or securities deposited
7 under this section are subject to the conditions required for a
8 bond under Section 2651.101. (V.T.I.C. Art. 9.38, Sec. (a)
9 (part).)

10 Source Law

11 (a) . . . In lieu of such bond any title
12 insurance agent or direct operation may deposit with
13 the Board cash or irrevocable letters of credit issued
14 by a financial institution in this state insured by an
15 agency of the United States government (or securities
16 approved by the Board) which deposits shall be subject
17 to the same conditions as provided for in said bond.

18 Revised Law

19 Sec. 2651.103. EXAMINATION OF LOSS COVERED BY BOND OR
20 DEPOSIT. (a) At any time it appears that a loss covered by a bond
21 or deposit has occurred, the department may require the title
22 insurance agent or direct operation to appear in Travis County,
23 with records the department determines to be proper, for an
24 examination.

25 (b) The department shall specify a date for the examination
26 that is not earlier than the 10th day or later than the 15th day
27 after the date of service of notice of the requirement to appear.

28 (c) If after the examination the department determines that
29 a loss covered by the bond or deposit has occurred, the department
30 shall immediately notify the surety on the bond, if applicable, and
31 prepare a written statement of the facts of the loss and deliver the
32 statement to the attorney general. (V.T.I.C. Art. 9.38, Sec. (b)
33 (part).)

34 Source Law

35 (b) If at any time it appears to the Board that a
36 loss covered by the bond or deposit has been suffered,
37 the Board may require the title insurance agent or
38 direct operation to appear in Travis County with such
39 records as the Board deems proper on a named date not

1 earlier than ten (10) days nor later than fifteen (15)
2 days from service of notice, and there conduct an
3 examination into the matter. If upon such examination
4 the Board is satisfied that a loss covered by the bond
5 or deposit has been suffered, the Board shall
6 immediately notify the surety and prepare a written
7 statement covering the facts and deliver it to the
8 Attorney General of Texas,

9 Revisor's Note

10 Section (b), V.T.I.C. Article 9.38, requires the
11 department to "notify the surety" if a loss covered by
12 a bond or deposit occurs. The revised law substitutes
13 "notify the surety on the bond, if applicable," for
14 "notify the surety" for clarity because if a title
15 insurance agent or direct operation elects to make a
16 deposit with the department instead of filing a bond,
17 as authorized by Section 2651.102, no surety exists to
18 receive notification.

19 Revised Law

20 Sec. 2651.104. INVESTIGATION BY ATTORNEY GENERAL. (a) On
21 receipt of a written statement under Section 2651.103, the attorney
22 general shall investigate the charges and, on determining that a
23 loss covered by the bond or deposit has occurred, shall enforce the
24 liability by collecting against the deposited cash or securities or
25 by filing suit on the bond.

26 (b) A suit brought under this section shall be filed in the
27 name of the department in Travis County for the benefit of all
28 parties who have suffered any loss covered by the bond or deposit.

29 (V.T.I.C. Art. 9.38, Sec. (b) (part).)

30 Source Law

31 (b) . . . [the Attorney General of Texas,]
32 whose duty it shall be to investigate the charges, and
33 if satisfied that a loss covered by the bond or deposit
34 has been suffered, then to enforce the liability
35 against cash or securities, or by suit on said bond in
36 Travis County in the name of the Board for the benefit
37 of all parties who have suffered any loss covered by
38 the bond or deposit.

39 [Sections 2651.105-2651.150 reserved for expansion]

1 SUBCHAPTER D. ANNUAL AUDIT

2 Revised Law

3 Sec. 2651.151. ANNUAL AUDIT OF TRUST FUND ACCOUNTS: TITLE
4 INSURANCE AGENTS AND DIRECT OPERATIONS. (a) Each title insurance
5 agent and direct operation shall have an annual audit made of trust
6 fund accounts. The agent or direct operation shall pay for the
7 audit.

8 (b) Not later than the 90th day after the date of the end of
9 the agent's or direct operation's fiscal year, the agent or direct
10 operation shall send by certified mail, postage prepaid, to the
11 department one copy of the audit report with a transmittal letter.
12 The agent shall also send a copy of the audit report and transmittal
13 letter to each title insurance company that the agent represents.
14 (V.T.I.C. Art. 9.39, Sec. (a).)

15 Source Law

16 Art. 9.39. (a) Every title insurance agent and
17 direct operation shall have an annual audit, at the
18 agent's or direct operation's expense, made of trust
19 fund accounts, and before the 91st day after the date
20 of the termination of its fiscal year, shall send by
21 certified mail, postage prepaid, to the department one
22 copy of such audit report with a letter of transmittal,
23 and each such agent, shall also send a copy of such
24 letter of transmittal and audit report to every title
25 insurance company which it represents.

26 Revised Law

27 Sec. 2651.152. ANNUAL AUDIT OF TRUST FUND ACCOUNTS: TITLE
28 INSURANCE COMPANIES. (a) Each title insurance company shall have
29 an annual audit made of trust fund accounts for each county in which
30 it operates in its own name. The company shall pay for the audit.

31 (b) Not later than the 90th day after the date of the end of
32 the title insurance company's fiscal year, the company shall send
33 by certified mail, postage prepaid, to the department one copy of
34 the audit report. (V.T.I.C. Art. 9.39, Sec. (b).)

35 Source Law

36 (b) Every title insurance company shall have an
37 annual audit, at its expense, made of trust fund
38 accounts for each county in which it operates in its
39 own name and before the 91st day after the date of the
40 termination of its fiscal year shall send by certified
41 mail, postage prepaid, to the department one copy of

1 such audit report.

2 Revised Law

3 Sec. 2651.153. RULES. The commissioner by rule shall
4 adopt:

5 (1) the standards for an audit; and

6 (2) the form of the required audit report. (V.T.I.C.
7 Art. 9.39, Sec. (c).)

8 Source Law

9 (c) The Commissioner shall promulgate
10 regulations setting forth the standards of audit and
11 the form of audit report required.

12 Revisor's Note

13 Section (c), V.T.I.C. Article 9.39, refers to
14 "regulations." The revised law substitutes "rule" for
15 "regulation" because, in the context of references to
16 state law, "regulation" and "rule" are synonymous, and
17 "rule" is more commonly used. Also, under Section
18 311.005(5), Government Code (Code Construction Act), a
19 rule is defined to include a regulation. That
20 definition applies to the revised law.

21 Revised Law

22 Sec. 2651.154. PERFORMANCE OF AUDIT BY PUBLIC
23 ACCOUNTANT. An audit required under this subchapter must be
24 performed by an independent certified public accountant or licensed
25 public accountant, or a firm composed of either. (V.T.I.C.
26 Art. 9.39, Sec. (d).)

27 Source Law

28 (d) Said audit shall be made by an independent
29 certified public accountant or licensed public
30 accountant, or a firm composed of either.

31 Revised Law

32 Sec. 2651.155. CONFIDENTIALITY OF AUDIT. The commissioner
33 may classify an audit report that is filed with the department by a
34 title insurance company under this subchapter as confidential and
35 privileged. (V.T.I.C. Art. 9.39, Sec. (f).)

1 Source Law

2 (g) If any agent, direct operation, or title
3 insurance company shall fail or refuse to furnish an
4 audit report within the time required, or shall
5 furnish an audit report which reveals any shortage or
6 other irregularity, or any practice not in keeping
7 with sound, honest business practices, the department
8 may, after notice to the agent, direct operation, or
9 each title insurance company involved and after a
10 hearing at which the agent, direct operation, or title
11 insurance company may offer evidence explaining or
12 excusing such omissions or irregularity, revoke the
13 license of such agent or direct operation or revoke the
14 certificate of authority of such title insurance
15 company.

16 Revisor's Note
17 (End of Subchapter)

18 Section (h), V.T.I.C. Article 9.39, allows an
19 appeal of any action taken by the commissioner under
20 that article to be taken under V.T.I.C. Article 1.04,
21 codified in 1999 as Subchapter D, Chapter 36, of this
22 code. The revised law omits the provision as redundant
23 because an action taken by the commissioner under
24 Article 9.39 is already subject to appeal in the manner
25 provided by Subchapter D, Chapter 36, and an
26 additional statement to that effect in this chapter is
27 unnecessary. The omitted law reads:

28 (h) Any agent, direct operation, or
29 title insurance company feeling aggrieved
30 by any action of the Commissioner shall have
31 the right to appeal under Article 1.04 of
32 this code.

33 [Sections 2651.158-2651.200 reserved for expansion]

34 SUBCHAPTER E. GENERAL REGULATION OF TITLE INSURANCE

35 AGENTS AND DIRECT OPERATIONS

36 Revised Law

37 Sec. 2651.201. LICENSE SURRENDER OR FORFEITURE. (a) A
38 title insurance agent or direct operation may voluntarily surrender
39 at any time a license issued under this chapter by giving notice to:

40 (1) the department; and

41 (2) the affected title insurance company.

42 (b) A title insurance agent or direct operation that
43 terminates the agency contract with a title insurance company

1 automatically forfeits the license under that company.

2 (c) A surrender or forfeiture of a license under this
3 section does not affect the culpability of the license holder for
4 conduct committed before the effective date of the surrender or
5 forfeiture. The department may institute a disciplinary proceeding
6 against the former license holder for conduct committed before the
7 effective date of the surrender or forfeiture. (V.T.I.C.
8 Art. 9.37, Secs. A, F.)

9 Source Law

10 Art. 9.37. A. Any title insurance agent or
11 direct operation may voluntarily surrender his license
12 at any time by giving notice to the Board and to the
13 title insurance company concerned. Any agent or
14 direct operation shall automatically forfeit the
15 license under the title insurance company represented
16 if he shall terminate his agency contract with such
17 company.

18 F. The voluntary surrender or automatic
19 forfeiture of a title insurance agent license or
20 direct operation license to the department under
21 Section A of this article does not affect the
22 culpability of the license holder for conduct of the
23 license holder committed before the effective date of
24 the surrender or forfeiture, and the commissioner may
25 institute a disciplinary proceeding against the
26 license holder for conduct of the license holder
27 committed before the effective date of the surrender
28 or forfeiture.

29 Revised Law

30 Sec. 2651.202. TRUST FUND ACCOUNT DISBURSEMENTS. (a) A
31 title insurance company, title insurance agent, or direct operation
32 may not disburse funds from a trust fund account until good funds
33 related to the transaction have been received and deposited in the
34 account in amounts sufficient to fund any disbursements from the
35 transaction.

36 (b) A title insurance company, title insurance agent, or
37 direct operation is not liable for a violation of this section if
38 the violation:

39 (1) was not intentional; and

40 (2) resulted from a bona fide error despite the
41 maintenance of procedures reasonably adopted to avoid the error.

42 (c) The commissioner shall adopt rules and definitions to

1 implement this section. (V.T.I.C. Art. 9.39A, Secs. (a) (part),
2 (b), (c) (part).)

3 Source Law

4 Art. 9.39A. (a) A title insurance company,
5 title insurance agent, direct operation, or . . .
6 shall not disburse funds from a trust fund account
7 until good funds related to the transaction in amounts
8 sufficient to fund any disbursements from the
9 transaction have been received and deposited to the
10 trust fund account.

11 (b) The State Board of Insurance shall adopt
12 rules and definitions to implement this Article.

13 (c) A title insurance company, title insurance
14 agent, direct operation, or . . . is not liable for a
15 violation of this Article if the violation was not
16 intentional and if it resulted from a bona fide error
17 notwithstanding the maintenance of procedure
18 reasonably adopted to avoid the error.

19 Revised Law

20 Sec. 2651.203. DISCLOSURE OF OWNERSHIP AND PREMIUM
21 INFORMATION. (a) A title insurance agent who receives a portion
22 of a premium shall disclose to each purchaser of a title insurance
23 policy or other title insurance form the following:

24 (1) each shareholder, owner, or partner owning or
25 controlling at least one percent of the agent;

26 (2) each shareholder, owner, or partner owning or
27 controlling at least 10 percent of an entity that owns or controls
28 at least one percent of the agent;

29 (3) each person who is not a full-time employee of the
30 agent and who receives a portion of the premium for services
31 performed on behalf of the agent in connection with the issuance of
32 a title insurance form; and

33 (4) the amount of premium that a person disclosed in
34 Subdivision (3) receives.

35 (b) The department shall prescribe the form of the
36 disclosure required by this section. (V.T.I.C. Art. 9.38, Sec.
37 (c).)

38 Source Law

39 (c) Each title insurance agent receiving a
40 portion of a premium shall, in a form prescribed by the
41 Board, disclose to each purchaser of a title insurance
42 policy or other title insurance form the following:

43 (1) each shareholder, owner, or partner

1 having, owning, or controlling one percent or more of
2 the title insurance agent;

3 (2) each shareholder, owner, or partner
4 having, owning, or controlling 10 percent or more of an
5 entity that has, owns, or controls one percent or more
6 of the title insurance agent;

7 (3) any person who is not a full-time
8 employee of the title insurance agent and who receives
9 any portion of the title insurance premium for
10 services performed on behalf of the title insurance
11 agent in connection with the issuance of a title
12 insurance form; and

13 (4) the amount of premium that any person
14 disclosed in accordance with Subdivision (3) of this
15 subsection shall receive.

16 Revisor's Note

17 Section (c), V.T.I.C. Article 9.38, refers to a
18 person "having, owning, or controlling" certain
19 percentages of a title insurance agent or related
20 entity. The revised law omits references to "having"
21 or "has" because the meaning of those terms is included
22 in the meaning of to "own or control."

23 Revised Law

24 Sec. 2651.204. CONTINUING EDUCATION. (a) To protect the
25 public and to preserve and improve the competence of license
26 holders, the department shall require as a condition of holding a
27 title insurance agent license that the license holder enroll in and
28 attend or teach continuing education consisting of class
29 instruction, lectures, seminars, or other forms of education
30 approved by the department for title insurance agents.

31 (b) The department shall prescribe the required number of
32 hours of continuing education, not to exceed 15 hours in each
33 two-year license period.

34 (c) Continuing education instruction must be designed to
35 refresh the license holder's understanding of:

36 (1) basic principles and coverages relating to title
37 insurance;

38 (2) recent and prospective changes in those principles
39 and coverages;

40 (3) applicable rules of the commissioner and laws;

41 (4) the proper conduct of the license holder's

1 business; and

2 (5) the duties and responsibilities of the license
3 holder.

4 (d) The department may permit a license holder to complete
5 an equivalent course of study and instruction by mail if, because of
6 the remote location of the license holder's residence or business,
7 the license holder is unable to attend educational sessions with
8 reasonable convenience.

9 (e) On written request by the license holder, the department
10 may extend the time for the license holder to comply with the
11 requirements of this section or may exempt the license holder from
12 all or part of the requirements for a license period if the
13 department determines that the license holder is unable to comply
14 with the requirements because of illness, medical disability, or
15 another extenuating circumstance beyond the control of the license
16 holder. The commissioner shall prescribe the criteria for an
17 extension or exemption by rule.

18 (f) The commissioner shall adopt rules to administer this
19 section. (V.T.I.C. Art. 9.58, Secs. A (part), B, C, D, E.)

20 Source Law

21 Art. 9.58. A. For protection of the public and
22 to preserve and improve competence of licensees, the
23 commissioner shall require as a condition to
24 continuation of license as a title insurance agent or
25 . . . that during the 24 months next preceding
26 expiration of the current license period the licensee
27 has enrolled in and attended or taught 15 hours or such
28 lesser amount established by the commissioner in class
29 instruction, lectures, seminars, or other forms of
30 education approved by the commissioner for the
31 particular license.

32 B. The instruction shall be designed to refresh
33 the licensee's understanding of basic principles and
34 coverages involved, recent and prospective changes in
35 those principles and coverages, applicable laws and
36 rules and regulations of the commissioner, proper
37 conduct of the licensee's business, and duties and
38 responsibilities of the licensee.

39 C. The commissioner may permit licensees who
40 because of remoteness of residence or business cannot
41 with reasonable convenience attend these educational
42 sessions to take and successfully complete an
43 equivalent course of study and instruction by mail.

44 D. The commissioner shall promulgate rules and
45 regulations to carry out the purposes and requirements
46 of this article.

47 E. On written request of the licensee, the

1 commissioner may extend the time for the licensee to
2 comply with the requirements of this article or may
3 exempt the licensee from some or all of the
4 requirements for a licensing period if the
5 commissioner finds that the licensee is unable to
6 comply with the requirements because of illness,
7 medical disability, or another extenuating
8 circumstance beyond the control of the licensee. The
9 criteria for such exemptions and extensions shall be
10 established by rule.

11 Revisor's Note

12 (1) Sections B and D, V.T.I.C. Article 9.58,
13 refer to "rules and regulations." Throughout this
14 chapter, references to "regulations" are omitted from
15 the revised law because under Section 311.005(5),
16 Government Code (Code Construction Act), a rule is
17 defined to include a regulation. That definition
18 applies to the revised law.

19 (2) Section C, V.T.I.C. Article 9.58, contains a
20 requirement that a license holder "successfully
21 complete" a course of study. The revised law omits the
22 reference to "successfully" because the requirement to
23 complete the course includes successful completion of
24 the course.

25 [Sections 2651.205-2651.250 reserved for expansion]

26 SUBCHAPTER F. TITLE INSURANCE COMPANY POWERS AND DUTIES
27 REGARDING TITLE INSURANCE AGENTS

28 Revised Law

29 Sec. 2651.251. EXAMINATION OF TRUST FUND ACCOUNTS BY TITLE
30 INSURANCE COMPANY. (a) A title insurance company may examine, at
31 any time, the trust fund accounts and related records of the
32 company's title insurance agents through the company's examiners or
33 auditors or through independent certified public accountants
34 commissioned by the company.

35 (b) The title insurance company shall pay for each
36 examination. (V.T.I.C. Art. 9.40 (part).)

37 Source Law

38 Art. 9.40. Any title insurance company may at
39 such time or times as it sees fit, through its
40 examiners or auditors or through independent certified

1 public accountants commissioned by it, examine the
2 trust fund accounts and records pertaining thereto of
3 any of its title insurance agents, such examination to
4 be made at the expense of the title insurance company;
5 or

6 Revised Law

7 Sec. 2651.252. SPECIAL REPORTS. A title insurance company
8 may require special reports from the company's title insurance
9 agents regarding any of its transactions. (V.T.I.C. Art. 9.40
10 (part).)

11 Source Law

12 Art. 9.40. . . . the title insurance company
13 may require special reports from any such agent
14 regarding any of its transactions. . . .

15 Revised Law

16 Sec. 2651.253. AUDIT OF UNUSED FORMS. (a) A title
17 insurance company shall periodically audit the unused forms in the
18 possession of each of the company's title insurance agents to
19 determine that all used forms have been reported to the company.

20 (b) A title insurance company shall conduct an audit
21 required by this section at least once every two years.

22 (c) A report of each audit conducted under this section
23 shall be made to the department. (V.T.I.C. Art. 9.40 (part).)

24 Source Law

25 Art. 9.40. . . . Each title insurance company
26 shall periodically, but at least every two years,
27 audit the unused forms in the possession of each of its
28 title insurance agents so as to determine that all used
29 forms have been reported to the title insurance
30 company. A report of each such audit shall be made to
31 the State Board of Insurance.

32 [Sections 2651.254-2651.300 reserved for expansion]

33 SUBCHAPTER G. LICENSE DENIAL AND DISCIPLINARY ACTION

34 Revised Law

35 Sec. 2651.301. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY
36 ACTION. The department may deny an application for a license or
37 discipline a title insurance agent or direct operation under
38 Sections 4005.102, 4005.103, and 4005.104 if the department
39 determines that the applicant or license holder has:

- 40 (1) wilfully violated this title;

1 (2) intentionally made a material misstatement in the
2 license application;

3 (3) obtained or attempted to obtain the license by
4 fraud or misrepresentation;

5 (4) misappropriated or converted to the applicant's or
6 license holder's own use or illegally withheld money belonging to a
7 title insurance company, an insured, or another person;

8 (5) been guilty of fraudulent or dishonest practices;

9 (6) materially misrepresented the terms and
10 conditions of a title insurance policy or contract; or

11 (7) failed to maintain:

12 (A) a separate and distinct accounting of escrow
13 funds; and

14 (B) an escrow bank account or accounts separate
15 and apart from all other accounts. (V.T.I.C. Art. 9.37, Sec. B.)

16 Source Law

17 B. The department may discipline any agent or
18 direct operation or deny an application under Section
19 5, Article 21.01-2, of this code and its subsequent
20 amendments if it finds that the applicant for or holder
21 of such license:

22 (1) Has wilfully violated any provision of
23 this Act;

24 (2) Has intentionally made a material
25 misstatement in the application for such license;

26 (3) Has obtained, or attempted to obtain,
27 such license by fraud or misrepresentation;

28 (4) Has misappropriated or converted to
29 his own use or illegally withheld money belonging to a
30 title insurance company, an insured or any other
31 person;

32 (5) Has been guilty of fraudulent or
33 dishonest practices;

34 (6) Has materially misrepresented the
35 terms and conditions of title insurance policies or
36 contracts; or

37 (7) Has failed to maintain a separate and
38 distinct accounting of escrow funds, and has failed to
39 maintain an escrow bank account or accounts separate
40 and apart from all other accounts.

41 Revisor's Note

42 Section B, V.T.I.C. Article 9.37, authorizes the
43 department to discipline an agent or direct operation
44 or deny an application "under Section 5, Article
45 21.01-2, of this code and its subsequent amendments."

1 Chapter 703, Acts of the 77th Legislature, Regular
2 Session, 2001, redesignated Section 5, Article 21.01-2
3 as Section 3A, Article 21.01-2, and amended the
4 section to provide that Subsections (c)-(f) of the
5 section do not apply to a person who is licensed or
6 holds a certificate of authority under V.T.I.C.
7 Chapter 9, revised as this title. Accordingly, the
8 revised law refers to Subsections (a) and (b) of
9 Section 3A, Article 21.01-2, revised as Sections
10 4005.102, 4005.103, and 4005.104. The revised law
11 omits the reference to "its subsequent amendments" for
12 the reason stated in Revisor's Note (1) to Section
13 2651.006.

14 Revised Law

15 Sec. 2651.302. LICENSE APPLICATION AFTER DENIAL, REFUSAL,
16 OR REVOCATION. (a) An applicant whose license application has
17 been denied or refused or a license holder whose license has been
18 revoked under this subchapter may not file another application for
19 a license as a title insurance agent or direct operation before the
20 first anniversary of:

21 (1) the effective date of the denial, refusal, or
22 revocation; or

23 (2) the date of a final court order affirming the
24 denial, refusal, or revocation if judicial review is sought.

25 (b) A license application filed after the time required by
26 this section may be denied by the department unless the applicant
27 shows good cause why the denial, refusal, or revocation should not
28 be a bar to the issuance of a license. (V.T.I.C. Art. 9.37, Sec.
29 D.)

30 Source Law

31 D. No applicant or licensee whose license has
32 been denied, refused or revoked hereunder shall be
33 entitled to file another application for a license as
34 an agent or direct operation within one year from the
35 effective date of such denial, refusal or revocation,
36 or, if judicial review of such denial, refusal or
37 revocation is sought, within one year from the date of

1 final court order or decree affirming such action.
2 Such application, when filed after one year, may be
3 refused by the Board unless the applicant shows good
4 cause why the denial, refusal or revocation of his
5 license shall not be deemed a bar to the issuance of a
6 new license.

7 Revisor's Note

8 Section D, V.T.I.C. Article 9.37, refers to a
9 "court order or decree." The revised law omits the
10 reference to "decree" because, in context, "court
11 order" and "decree" have the same meaning and the
12 former term is more commonly used.

13 Revisor's Note
14 (End of Subchapter)

15 Section E, V.T.I.C. Article 9.37, allows an
16 appeal of a disciplinary action or denial of an
17 application under that article to be taken under
18 V.T.I.C. Article 1.04, codified in 1999 as Subchapter
19 D, Chapter 36, of this code. The revised law omits the
20 provision as redundant because a disciplinary action
21 or denial of an application under Article 9.37 is
22 already subject to appeal in the manner provided by
23 Subchapter D, Chapter 36, and an additional statement
24 to that effect in this chapter is unnecessary. The
25 omitted law reads:

26 E. A disciplinary action or denial of
27 an application under this article may be
28 appealed under Article 1.04 of this code and
29 its subsequent amendments.

30 CHAPTER 2652. ESCROW OFFICERS

31 SUBCHAPTER A. GENERAL PROVISIONS

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30 CHAPTER 2652. ESCROW OFFICERS

31 SUBCHAPTER A. GENERAL PROVISIONS

32 Revised Law

33 Sec. 2652.001. LICENSE AND BOND OR DEPOSIT REQUIRED. An

34 individual may not act as an escrow officer unless the individual:

1 (1) holds a license issued by the department; and
2 (2) maintains a surety bond or deposit required under
3 Subchapter C. (V.T.I.C. Art. 9.41, Sec. A (part); New.)

4 Source Law

5 Art. 9.41. A. No person shall act in the
6 capacity of escrow officer without (1) being licensed
7 by the Board, and (2) obtaining and maintaining a
8 surety bond as required by Article 9.45; and

9 Revisor's Note

10 (1) Section A, V.T.I.C. Article 9.41, refers to
11 the "Board," meaning the State Board of Insurance.
12 Chapter 685, Acts of the 73rd Legislature, Regular
13 Session, 1993, abolished the board and transferred its
14 functions to the commissioner of insurance and the
15 Texas Department of Insurance. Throughout this
16 chapter, references to the board have been changed
17 appropriately.

18 (2) Section A, V.T.I.C. Article 9.41, provides
19 that an individual may not act as an escrow officer
20 without "obtaining and maintaining a surety bond as
21 required by Article 9.45." The revised law omits the
22 reference to "obtaining" because, in context,
23 "obtaining" is included in the meaning of
24 "maintaining." The revised law also adds a reference
25 to other deposits permitted as an alternative to a bond
26 under Article 9.45, revised as Subchapter C, to
27 provide clarity and for the convenience of the reader.

28 Revised Law

29 Sec. 2652.002. EMPLOYMENT OF ESCROW OFFICER. (a) A title
30 insurance agent or direct operation may not employ an individual as
31 an escrow officer unless the individual holds a license and
32 maintains a surety bond or deposit as required by this chapter.

33 (b) A title insurance agent or direct operation may not
34 permit an individual to act as an escrow officer in this state
35 before the agent or direct operation has complied with Sections

1 2652.151 and 2652.152 with respect to the individual. (V.T.I.C.
2 Art. 9.41, Sec. A (part); Art. 9.42, Sec. 1(a) (part); New.)

3 Source Law

4 Art. 9.41. A. . . . no title insurance agent
5 or direct operation shall employ any person as escrow
6 officer who is not licensed and bonded in accordance
7 with the provisions of this Act.

8 Art. 9.42

9 Sec. 1. (a) . . . No title insurance agent or
10 direct operation shall permit any person to act as
11 escrow officer within the state until the foregoing
12 conditions have been complied with, and the Board has
13 granted the said license.

14 Revisor's Note

15 Section A, V.T.I.C. Article 9.41, refers to a
16 "bonded" escrow officer. The revised law adds a
17 reference to a deposit under this chapter for the
18 reason stated in Revisor's Note (2) to Section
19 2652.001.

20 Revised Law

21 Sec. 2652.003. ATTORNEY ACTING AS ESCROW
22 OFFICER. (a) Notwithstanding Section 2652.001, an attorney is
23 not required to be licensed as an escrow officer to perform the
24 duties of an escrow officer as defined by Section 2501.003.

25 (b) An attorney may hold a license to act as an escrow
26 officer. An employee of an attorney licensed as an escrow officer
27 also may hold a license to act as an escrow officer. An attorney
28 licensed as an escrow officer shall comply with the provisions of
29 this code that apply to escrow officers and trust funds as if the
30 attorney were a title insurance agent.

31 (c) Notwithstanding any other provision of this chapter, a
32 title insurance company or title insurance agent may not permit an
33 attorney to conduct the attorney's business in the name of the
34 company or agent unless the attorney and the attorney's bona fide
35 employees who close transactions are licensed escrow officers.
36 (V.T.I.C. Art. 9.41, Secs. B, C.)

37 Source Law

38 B. No attorney shall be required to be licensed

1 as an escrow officer in order to perform the duties of
2 an escrow officer as defined in Article 9.02(g) of this
3 Chapter. However, an attorney may become licensed as
4 an escrow officer, and the employees of an attorney
5 licensed as an escrow officer may become licensed
6 escrow officers, in which case the attorney shall
7 comply with all requirements of this Code with regard
8 to escrow officers and trust funds, as if the attorney
9 were a title insurance agent.

10 C. Notwithstanding any provision in this
11 Chapter to the contrary, no title insurance company or
12 title insurance agent shall permit an attorney to
13 conduct the attorney's business in the name of such
14 title insurance company or title insurance agent
15 unless the attorney and the attorney's bona fide
16 employees who close transactions are licensed as
17 escrow officers.

18 Revisor's Note

19 Section B, V.T.I.C. Article 9.41, provides that
20 an attorney is not required to be licensed as an escrow
21 officer to perform the duties of an escrow officer.
22 This provision is an exception to Section A, V.T.I.C.
23 Article 9.41, revised in relevant part as Section
24 2652.001, which provides that an individual may not
25 act as an escrow officer without holding a license.
26 The revised law in this section adds
27 "[n]otwithstanding Section 2652.001" to provide
28 clarity and for the convenience of the reader.

29 Revised Law

30 Sec. 2652.004. TRUST FUND ACCOUNT DISBURSEMENTS. (a) An
31 escrow officer may not disburse funds from a trust fund account
32 until good funds related to the transaction have been received and
33 deposited in the account in amounts sufficient to fund any
34 disbursements from the transaction.

35 (b) An escrow officer is not liable for a violation of this
36 section if the violation:

37 (1) was not intentional; and

38 (2) resulted from a bona fide error despite the
39 maintenance of procedures reasonably adopted to avoid the error.

40 (c) The commissioner shall adopt rules and definitions to
41 implement this section. (V.T.I.C. Art. 9.39A, Secs. (a) (part),
42 (b), (c) (part).)

1 Source Law

2 Art. 9.39A. (a) . . . escrow officer shall not
3 disburse funds from a trust fund account until good
4 funds related to the transaction in amounts sufficient
5 to fund any disbursements from the transaction have
6 been received and deposited to the trust fund account.

7 (b) The State Board of Insurance shall adopt
8 rules and definitions to implement this Article.

9 (c) . . . escrow officer is not liable for a
10 violation of this Article if the violation was not
11 intentional and if it resulted from a bona fide error
12 notwithstanding the maintenance of procedure
13 reasonably adopted to avoid the error.

14 Revised Law

15 Sec. 2652.005. ESCROW ACCOUNT AUDIT. Each escrow account
16 used by a licensed escrow officer for closing a transaction is
17 subject to the audit requirements of Subchapter D, Chapter 2651.
18 (V.T.I.C. Art. 9.41, Sec. D.)

19 Source Law

20 D. All escrow accounts utilized by licensed
21 escrow officers for closing transactions shall be
22 subject to the audit requirements contained in Article
23 9.39 of this Code.

24 Revised Law

25 Sec. 2652.006. RECORD OF ESCROW OFFICERS. The department
26 shall maintain a record of the name and address of each escrow
27 officer licensed by the department in a manner that ensures that the
28 escrow officers employed by any title insurance agent or direct
29 operation in this state may be conveniently determined. (V.T.I.C.
30 Art. 9.42, Sec. 1(c).)

31 Source Law

32 (c) The Board shall keep a record of the names
33 and addresses of all escrow officers licensed by the
34 Board in such manner that the escrow officers employed
35 by any title insurance agent or direct operation
36 within the state may be conveniently determined.

37 [Sections 2652.007-2652.050 reserved for expansion]

38 SUBCHAPTER B. LICENSE APPLICATION AND RENEWAL

39 Revised Law

40 Sec. 2652.051. LICENSE APPLICATION. (a) Before an
41 initial license is issued to an individual to act as an escrow
42 officer in this state for a title insurance agent or direct
43 operation, the title insurance agent or direct operation must file

1 an application for an escrow officer's license with the department
2 on forms provided by the department.

3 (b) The application must be:

4 (1) accompanied by a nonrefundable license fee; and

5 (2) signed and sworn to by the title insurance agent or
6 direct operation and by the proposed escrow officer.

7 (c) The completed application must state that:

8 (1) the proposed escrow officer is an individual who
9 is a bona fide resident of this state;

10 (2) the proposed escrow officer is an attorney or is a
11 bona fide employee of:

12 (A) an attorney licensed as an escrow officer; or

13 (B) a title insurance agent or direct operation;

14 (3) the proposed escrow officer has reasonable
15 experience or instruction in the field of title insurance; and

16 (4) the title insurance agent or direct operation does
17 not know of any fact or condition that disqualifies the proposed
18 escrow officer from receiving a license. (V.T.I.C. Art. 9.43,
19 Secs. A (part), B.)

20 Source Law

21 Art. 9.43. A. Before an initial license is
22 issued to any person to act as escrow officer within
23 the State of Texas for any title insurance agent or
24 direct operation, there shall be first filed by such
25 title insurance agent or direct operation with the
26 Board an application for an escrow officer's license on
27 forms provided by the Board, accompanied by a
28 nonrefundable license fee The application
29 shall be signed and duly sworn to by such title
30 insurance agent or direct operation and by the
31 proposed escrow officer.

32 B. Such application shall contain the
33 following:

34 (1) that the proposed escrow officer is a
35 natural person, a bona fide resident of the State of
36 Texas, and either an attorney or a bona fide employee
37 of an attorney licensed as an escrow officer, a bona
38 fide employee of a title insurance agent, or a bona
39 fide employee of a direct operation;

40 (2) that the proposed escrow officer has
41 reasonable experience or instruction in the field of
42 title insurance; and

43 (3) that the direct operation or title
44 insurance agent knows of no fact or condition which
45 would disqualify the proposed escrow officer from
46 receiving a license.

1 Revised Law

2 Sec. 2652.052. LICENSE AND RENEWAL FEES. (a) The
3 department shall prescribe the license fee in an amount not to
4 exceed \$50.

5 (b) License fees, and renewal fees collected under Section
6 2652.152, shall be deposited to the credit of the Texas Department
7 of Insurance operating account to be used by the department to
8 enforce this chapter and any other law of this state that regulates
9 escrow officers for title insurance agents or direct operations.
10 (V.T.I.C. Art. 9.43, Sec. A (part).)

11 Source Law

12 A. . . . license fee in an amount not to exceed
13 Fifty Dollars (\$50) as determined by the Board, which
14 fees including license renewal fees under Article 9.42
15 shall be deposited in the state treasury to the credit
16 of the State Board of Insurance operating fund to be
17 used by the State Board of Insurance to enforce the
18 provisions of this article and all laws of this state
19 governing and regulating escrow officers for such
20 title insurance agents or direct operation. . . .

21 Revisor's Note

22 Section A, V.T.I.C. Article 9.43, requires
23 license and renewal fees to be deposited in the state
24 treasury to the credit of the State Board of Insurance
25 operating fund. Under the authority of Chapter 4, Acts
26 of the 72nd Legislature, 1st Called Session, 1991, the
27 Texas Department of Insurance operating fund (the
28 later name of the State Board of Insurance operating
29 fund) was converted to an account in the general
30 revenue fund. The revised law is drafted accordingly.

31 Revised Law

32 Sec. 2652.053. LICENSE ISSUANCE. The department shall
33 issue a license if the department determines, based on the
34 application and the department's investigation, that the
35 requirements of Section 2652.051 are satisfied. (V.T.I.C.
36 Art. 9.43, Sec. C.)

37 Source Law

38 C. The Board shall grant such license, if it

1 determines from the application and its own
2 investigation that the foregoing requirements have
3 been met.

4 Revised Law

5 Sec. 2652.054. DUPLICATE LICENSE. (a) The department
6 shall collect in advance a fee from a title insurance agent or
7 direct operation that requests a duplicate license.

8 (b) The department shall prescribe the fee in an amount not
9 to exceed \$20. (V.T.I.C. Art. 9.43, Sec. D.)

10 Source Law

11 D. The Commissioner of Insurance shall collect
12 in advance from agents requesting duplicate licenses a
13 fee not to exceed \$20. The State Board of Insurance
14 shall determine the amount of the fee.

15 Revised Law

16 Sec. 2652.055. LICENSE TERM. Unless a system of staggered
17 license renewal is adopted under Section 4003.002, a license
18 expires on the second June 1 following the date of issuance.
19 (V.T.I.C. Art. 9.42, Sec. 1(b) (part).)

20 Source Law

21 (b) Unless a system of staggered renewal is
22 adopted under Article 21.01-2 of this code and its
23 subsequent amendments, a license shall continue in
24 force until the second June 1 after its issuance,
25 unless previously cancelled. . . .

26 Revisor's Note

27 (1) Section 1(b), V.T.I.C. Article 9.42, refers
28 to Article 21.01-2 and "its subsequent amendments."
29 The revised law omits "its subsequent amendments" in
30 this section and throughout this chapter because under
31 Section 311.027, Government Code (Code Construction
32 Act), unless expressly provided otherwise, a reference
33 to a statute applies to all reenactments, revisions,
34 or amendments of the statute.

35 (2) Section 1(b), V.T.I.C. Article 9.42,
36 provides that an escrow officer's license expires on a
37 certain date "unless previously cancelled." The
38 revised law omits the quoted language as unnecessary
39 because cancellation of the license would cause the

1 license to no longer be valid, and thus the expiration
2 date would be rendered meaningless because of the
3 nature of cancellation and not because of the omitted
4 statutory provision.

5 Revised Law

6 Sec. 2652.056. AUTOMATIC TERMINATION OF LICENSE. The
7 license of each escrow officer employed by a title insurance agent
8 or direct operation that surrenders its license or has its license
9 revoked by the department is automatically terminated without
10 notice. (V.T.I.C. Art. 9.42, Sec. 1(b) (part).)

11 Source Law

12 (b) . . . Provided, however, that if any title
13 insurance agent or direct operation surrenders its
14 license or has its license revoked by the Board, all
15 existing licenses of its escrow officers shall
16 automatically terminate without notice.

17 Revised Law

18 Sec. 2652.057. LICENSE SURRENDER OR FORFEITURE. (a) An
19 escrow officer may voluntarily surrender the escrow officer's
20 license at any time by giving notice to the department.

21 (b) An escrow officer automatically forfeits the escrow
22 officer's license if the officer is not employed as an escrow
23 officer.

24 (c) A surrender or forfeiture of a license under this
25 section does not affect the culpability of the license holder for
26 conduct committed before the effective date of the surrender or
27 forfeiture. The department may institute a disciplinary proceeding
28 against the former license holder for conduct committed before the
29 effective date of the surrender or forfeiture. (V.T.I.C.
30 Art. 9.44, Secs. 1, 6.)

31 Source Law

32 Art. 9.44

33 Sec. 1. Any escrow officer may voluntarily
34 surrender the escrow officer's license at any time by
35 giving notice to the Board. An escrow officer shall
36 likewise automatically forfeit the license if the
37 officer shall fail to be employed as an escrow officer.

38 Sec. 6. The voluntary surrender or automatic
39 forfeiture of an escrow officer license to the

1 department under Section 1 of this article does not
2 affect the culpability of the license holder for
3 conduct of the license holder committed before the
4 effective date of the surrender or forfeiture, and the
5 commissioner may institute a disciplinary proceeding
6 against the license holder for conduct of the license
7 holder committed before the effective date of the
8 surrender or forfeiture.

9 Revised Law

10 Sec. 2652.058. CONTINUING EDUCATION. (a) To protect the
11 public and to preserve and improve the competence of license
12 holders, the department shall require as a condition of holding an
13 escrow officer license that the license holder enroll in and attend
14 or teach continuing education consisting of class instruction,
15 lectures, seminars, or other forms of education approved by the
16 department for escrow officers.

17 (b) The department shall prescribe the required number of
18 hours of continuing education, not to exceed 15 hours in each
19 two-year license period.

20 (c) Continuing education instruction must be designed to
21 refresh the license holder's understanding of:

22 (1) basic principles and coverages relating to title
23 insurance;

24 (2) recent and prospective changes in those principles
25 and coverages;

26 (3) applicable rules of the commissioner and laws;

27 (4) the proper conduct of the license holder's
28 business; and

29 (5) the duties and responsibilities of the license
30 holder.

31 (d) The department may permit a license holder to complete
32 an equivalent course of study and instruction by mail if, because of
33 the remote location of the license holder's residence or business,
34 the license holder is unable to attend educational sessions with
35 reasonable convenience.

36 (e) On written request by the license holder, the department
37 may extend the time for the license holder to comply with the
38 requirements of this section or may exempt the license holder from

1 all or part of the requirements for a license period if the
2 department determines that the license holder is unable to comply
3 with the requirements because of illness, medical disability, or
4 another extenuating circumstance beyond the control of the license
5 holder. The commissioner shall prescribe the criteria for an
6 extension or exemption by rule.

7 (f) The commissioner shall adopt rules to administer this
8 section. (V.T.I.C. Art. 9.58, Secs. A (part), B, C, D, E.)

9 Source Law

10 Art. 9.58. A. For protection of the public and
11 to preserve and improve competence of licensees, the
12 commissioner shall require as a condition to
13 continuation of license as a[n] . . . escrow officer
14 that during the 24 months next preceding expiration of
15 the current license period the licensee has enrolled
16 in and attended or taught 15 hours or such lesser
17 amount established by the commissioner in class
18 instruction, lectures, seminars, or other forms of
19 education approved by the commissioner for the
20 particular license.

21 B. The instruction shall be designed to refresh
22 the licensee's understanding of basic principles and
23 coverages involved, recent and prospective changes in
24 those principles and coverages, applicable laws and
25 rules and regulations of the commissioner, proper
26 conduct of the licensee's business, and duties and
27 responsibilities of the licensee.

28 C. The commissioner may permit licensees who
29 because of remoteness of residence or business cannot
30 with reasonable convenience attend these educational
31 sessions to take and successfully complete an
32 equivalent course of study and instruction by mail.

33 D. The commissioner shall promulgate rules and
34 regulations to carry out the purposes and requirements
35 of this article.

36 E. On written request of the licensee, the
37 commissioner may extend the time for the licensee to
38 comply with the requirements of this article or may
39 exempt the licensee from some or all of the
40 requirements for a licensing period if the
41 commissioner finds that the licensee is unable to
42 comply with the requirements because of illness,
43 medical disability, or another extenuating
44 circumstance beyond the control of the licensee. The
45 criteria for such exemptions and extensions shall be
46 established by rule.

47 Revisor's Note

48 (1) Sections B and D, V.T.I.C. Article 9.58,
49 refer to "rules and regulations." The references to
50 "regulations" are omitted from the revised law because
51 under Section 311.005(5), Government Code (Code
52 Construction Act), a rule is defined to include a

1 regulation. That definition applies to the revised
2 law.

3 (2) Section C, V.T.I.C. Article 9.58, contains a
4 requirement that an individual "successfully
5 complete" a course of study. The revised law omits the
6 reference to "successfully" because the requirement to
7 complete the course includes successful completion of
8 the course.

9 [Sections 2652.059-2652.100 reserved for expansion]

10 SUBCHAPTER C. BOND AND DEPOSIT REQUIREMENTS

11 Revised Law

12 Sec. 2652.101. BOND REQUIRED. (a) A title insurance
13 agent or direct operation shall obtain, at its own expense, a bond
14 for its escrow officers payable to the department. The bond shall
15 obligate the principal and surety to pay for any pecuniary loss
16 sustained by the title insurance agent or direct operation through
17 an act of fraud, dishonesty, forgery, theft, embezzlement, or
18 wilful misapplication by an escrow officer, either directly and
19 alone or in conspiracy with another person.

20 (b) The bond must be:

21 (1) of a type approved by the department; and

22 (2) issued by a surety licensed by the department to do
23 business in this state. (V.T.I.C. Art. 9.45, Sec. (a) (part).)

24 Source Law

25 Art. 9.45. (a) Every title insurance agent and
26 direct operation shall procure at its expense for its
27 escrow officers, a bond of such type as may be approved
28 by the State Board of Insurance with a surety licensed
29 by the Board to do business in Texas, . . . payable to
30 the State Board of Insurance, which bond shall
31 obligate the principal and surety to pay such
32 pecuniary loss as the title insurance agent or direct
33 operation shall sustain through acts of fraud,
34 dishonesty, forgery, theft, embezzlement, or wilful
35 misapplication on the part of such escrow officer,
36 either directly and alone, or in connivance with
37 others. . . .

38 Revised Law

39 Sec. 2652.102. ALTERNATIVE TO BOND. (a) Instead of the
40 bond required by Section 2652.101, a title insurance agent or

1 direct operation may deposit with the department:

2 (1) cash;

3 (2) irrevocable letters of credit issued by a
4 financial institution insured by an agency of the United States; or

5 (3) securities approved by the department.

6 (b) The cash, letters of credit, or securities deposited
7 under this section are subject to the conditions required for a bond
8 under Section 2652.101. (V.T.I.C. Art. 9.45, Sec. (a) (part).)

9 Source Law

10 (a) . . . In lieu of such bond, cash or
11 irrevocable letters of credit issued by a financial
12 institution insured by an agency of the United States
13 government (or securities approved by the Board) . . .
14 may be deposited by the title insurance agent or direct
15 operation with the Board, subject to the same
16 conditions as provided for in said bond.

17 Revised Law

18 Sec. 2652.103. AMOUNT OF BOND OR DEPOSIT. The amount of
19 the bond or deposit required under this subchapter is determined by
20 multiplying the number of escrow officers employed by the title
21 insurance agent or direct operation by \$5,000, except that the
22 maximum amount of the bond or deposit required under this
23 subchapter is \$50,000. (V.T.I.C. Art. 9.45, Sec. (a) (part).)

24 Source Law

25 (a) . . . a bond . . . in an amount to be
26 determined by multiplying the number of escrow
27 officers by Five Thousand Dollars (\$5,000) but not
28 exceeding Fifty Thousand Dollars (\$50,000) . . . [In
29 lieu of such bond, cash or irrevocable letters of
30 credit . . . or securities] . . . in multiples of Five
31 Thousand Dollars (\$5,000) per escrow officer employed
32 but not exceeding Fifty Thousand Dollars (\$50,000) may
33 be deposited

34 Revised Law

35 Sec. 2652.104. EXAMINATION OF LOSS COVERED BY BOND OR
36 DEPOSIT. (a) At any time it appears that a loss covered by a bond
37 or deposit has occurred, the department may require the escrow
38 officer to appear in Travis County, with records the department
39 determines to be proper, for an examination.

40 (b) The department shall specify a date for the examination
41 that is not earlier than the 10th day or later than the 15th day

1 after the date of service of notice of the requirement to appear.
2 Copies of the notice shall be sent to any title insurance agent or
3 direct operation concerned.

4 (c) If after the examination the department determines that
5 a loss covered by the bond or deposit has occurred, the department
6 shall immediately notify the appropriate title insurance agent or
7 direct operation and the surety on the bond, if applicable, and
8 prepare a written statement of the facts of the loss and deliver the
9 statement to the attorney general. (V.T.I.C. Art. 9.45, Sec. (b)
10 (part).)

11 Source Law

12 (b) If at any time it appears to the Board that a
13 loss covered by the bond or deposit has been suffered,
14 the Board may require the escrow officer to appear in
15 Travis County with such records as the Board deems
16 proper on a named date not earlier than ten (10) days
17 nor later than fifteen (15) days from service of
18 notice, copies of which notice shall also be sent to
19 any title insurance agent or direct operation
20 concerned, and there conduct an examination into the
21 matter. If upon such examination the Board is
22 satisfied that a loss covered by the bond or deposit
23 has been suffered, the Board shall immediately notify
24 the surety and title insurance agent or direct
25 operation concerned and prepare a written statement
26 covering the facts and deliver it to the Attorney
27 General of Texas

28 Revisor's Note

29 Section (b), V.T.I.C. Article 9.45, requires the
30 department to "notify the surety" if a loss covered by
31 a bond or deposit occurs. The revised law substitutes
32 "notify the surety on the bond, if applicable," for
33 "notify the surety" for clarity because if a title
34 insurance agent or direct operation elects to make a
35 deposit with the department instead of filing a bond,
36 as authorized by Section 2652.102, no surety exists to
37 receive notification.

38 Revised Law

39 Sec. 2652.105. INVESTIGATION BY ATTORNEY GENERAL. (a) On
40 receipt of a written statement under Section 2652.104, the attorney
41 general shall investigate the charges and, on determining that a

1 loss covered by the bond or deposit has occurred, shall enforce the
2 liability by collecting against the deposited cash or securities or
3 by filing suit on the bond.

4 (b) A suit brought under this section shall be filed in the
5 name of the department in Travis County for the benefit of all
6 parties who have suffered any loss covered by the bond or deposit.
7 (V.T.I.C. Art. 9.45, Sec. (b) (part).)

8 Source Law

9 (b) . . . the Attorney General of Texas, whose
10 duty it shall be to investigate the charges, and if
11 satisfied that a loss covered by the bond or deposit
12 has been suffered, then to enforce the liability
13 against cash or securities, or by suit on said bond in
14 Travis County in the name of the Board for the benefit
15 of all parties who have suffered any loss covered by
16 the bond or deposit.

17 [Sections 2652.106-2652.150 reserved for expansion]

18 SUBCHAPTER D. DUTIES OF TITLE INSURANCE AGENTS AND DIRECT
19 OPERATIONS REGARDING ESCROW OFFICERS

20 Revised Law

21 Sec. 2652.151. LIST OF ESCROW OFFICERS. (a) A title
22 insurance agent or direct operation shall certify to the
23 department, not later than the expiration date of the title
24 insurance agent's or direct operation's license, the name and
25 address of each individual employed by the title insurance agent or
26 direct operation to serve as an escrow officer in this state.

27 (b) The certification required by this section must be on a
28 form provided by the department. (V.T.I.C. Art. 9.42, Sec. 1(a)
29 (part).)

30 Source Law

31 Sec. 1. (a) Each title insurance agent and
32 direct operation licensed and operating under the
33 provisions of this Act shall certify to the Board on or
34 before the expiration date of its license on forms
35 provided by the Board the names and addresses of every
36 person employed by it to serve in the capacity of
37 escrow officer within the state

38 Revised Law

39 Sec. 2652.152. RENEWAL. A title insurance agent or direct
40 operation shall apply for renewal and pay a nonrefundable license

1 renewal fee prescribed by the department in an amount not to exceed
2 \$50 for each escrow officer listed by the title insurance agent or
3 direct operation under Section 2652.151. (V.T.I.C. Art. 9.42, Sec.
4 1(a) (part).)

5 Source Law

6 (a) Each title insurance agent and direct
7 operation licensed and operating under the provisions
8 of this Act [shall certify . . . the names and
9 addresses of every person employed by it to serve in
10 the capacity of] escrow officer . . . , whose license
11 is to be renewed, and shall apply for and pay a
12 nonrefundable license renewal fee in an amount not to
13 exceed Fifty Dollars (\$50) as determined by the Board
14 for each person included in said list. . . .

15 Revised Law

16 Sec. 2652.153. NOTICE OF TERMINATION. A title insurance
17 agent or direct operation that terminates the employment of a
18 licensed escrow officer shall:

19 (1) immediately notify the department in writing of
20 the termination and request cancellation of the license; and

21 (2) notify the escrow officer of the action by the
22 title insurance agent or direct operation. (V.T.I.C. Art. 9.42,
23 Sec. 1(a) (part).)

24 Source Law

25 (a) . . . If it shall terminate any licensed
26 escrow officer, it shall immediately notify the Board
27 in writing of such act and request cancellation of the
28 license, notifying such escrow officer of such
29 action. . . .

30 [Sections 2652.154-2652.200 reserved for expansion]

31 SUBCHAPTER E. LICENSE DENIAL AND DISCIPLINARY ACTION

32 Revised Law

33 Sec. 2652.201. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY
34 ACTION. The department may deny an application for a license or
35 discipline an escrow officer under Sections 4005.102, 4005.103, and
36 4005.104 if the department determines that the applicant or license
37 holder has:

38 (1) wilfully violated this title;

39 (2) intentionally made a material misstatement in the
40 license application;

1 (3) obtained or attempted to obtain the license by
2 fraud or misrepresentation;

3 (4) misappropriated or converted to the escrow
4 officer's own use or illegally withheld money belonging to a title
5 insurance agent, direct operation, or another person;

6 (5) been guilty of fraudulent or dishonest practices;

7 (6) materially misrepresented the terms and
8 conditions of a title insurance policy or contract; or

9 (7) failed to complete all educational requirements.

10 (V.T.I.C. Art. 9.44, Sec. 2.)

11 Source Law

12 Sec. 2. The department may discipline an escrow
13 officer or deny an application under Section 5,
14 Article 21.01-2, of this code and its subsequent
15 amendments if it finds that the applicant for or holder
16 of such license:

17 (1) has wilfully violated any provision of
18 this Act;

19 (2) has intentionally made a material
20 misstatement in the application for such license;

21 (3) has obtained, or attempted to obtain,
22 such license by fraud or misrepresentation;

23 (4) has misappropriated or converted to
24 the escrow officer's own use or illegally withheld
25 money belonging to a direct operation, title insurance
26 agent, or any other person;

27 (5) has been guilty of fraudulent or
28 dishonest practices;

29 (6) has materially misrepresented the
30 terms and conditions of title insurance policies or
31 contracts; or

32 (7) has failed to complete all educational
33 requirements.

34 Revisor's Note

35 Section 2, V.T.I.C. Article 9.44, authorizes the
36 department to discipline an escrow officer or deny an
37 application "under Section 5, Article 21.01-2, of this
38 code and its subsequent amendments." Chapter 703,
39 Acts of the 77th Legislature, Regular Session, 2001,
40 redesignated Section 5, Article 21.01-2 as Section 3A,
41 Article 21.01-2, and amended the section to provide
42 that Subsections (c)-(f) of the section do not apply to
43 a person who is licensed or holds a certificate of
44 authority under V.T.I.C. Chapter 9, revised as this

1 title. Accordingly, the revised law refers to
2 Subsections (a) and (b) of Section 3A, Article
3 21.01-2, revised as Sections 4005.102, 4005.103, and
4 4005.104. The revised law omits the reference to "its
5 subsequent amendments" for the reason stated in
6 Revisor's Note (1) to Section 2652.055.

7 Revised Law

8 Sec. 2652.202. LICENSE APPLICATION AFTER DENIAL, REFUSAL,
9 OR REVOCATION. (a) An applicant whose license application has
10 been denied or refused or a license holder whose license has been
11 revoked under this subchapter may not file another application for
12 a license as an escrow officer before the first anniversary of:

13 (1) the effective date of the denial, refusal, or
14 revocation; or

15 (2) the date of a final court order affirming the
16 denial, refusal, or revocation if judicial review is sought.

17 (b) A license application filed after the time required by
18 this section may be denied by the department unless the applicant
19 shows good cause why the denial, refusal, or revocation should not
20 be a bar to the issuance of a license. (V.T.I.C. Art. 9.44, Sec.
21 4.)

22 Source Law

23 Sec. 4. No applicant or licensee whose license
24 has been denied, refused or revoked hereunder shall be
25 entitled to file another application for a license as
26 an escrow officer within one year from the effective
27 date of such denial, refusal or revocation, or, if
28 judicial review of such denial, refusal or revocation
29 is sought, within one year from the date of final court
30 order or decree affirming such action. Such
31 application, when filed after one year, may be refused
32 by the Board unless the applicant shows good cause why
33 the denial, refusal or revocation of his license shall
34 not be deemed a bar to the issuance of a new license.

35 Revisor's Note

36 Section 4, V.T.I.C. Article 9.44, refers to a
37 "court order or decree." The revised law omits the
38 reference to "decree" because, in context, "court
39 order" and "decree" have the same meaning, and the

1 former term is more commonly used.

2 Revisor's Note
3 (End of Chapter)

4 Section 5, V.T.I.C. Article 9.44, allows an
5 appeal of a disciplinary action or denial of an
6 application under that article to be taken under
7 V.T.I.C. Article 1.04, codified in 1999 as Subchapter
8 D, Chapter 36, Insurance Code. The revised law omits
9 the provision as redundant because a disciplinary
10 action or denial of an application under Article 9.44
11 is already subject to appeal in the manner provided by
12 Subchapter D, Chapter 36, and an additional statement
13 to that effect in this chapter is unnecessary. The
14 omitted law reads:

15 Sec. 5. A disciplinary action or
16 denial of an application under this article
17 may be appealed under Article 1.04 of this
18 code and its subsequent amendments.

19 [Chapters 2653-2700 reserved for expansion]

20 SUBTITLE E. THE BUSINESS OF TITLE INSURANCE

21 CHAPTER 2701. GENERAL PROVISIONS

22 Sec. 2701.001. ABSTRACT OF TITLE DISTINGUISHED; PROHIBITION

23 ON REGULATION OF ABSTRACT OF TITLE 1644

24 Sec. 2701.002. CONSTRUCTION OF CHAPTER 39, BUSINESS &

25 COMMERCE CODE 1646

26 CHAPTER 2701. GENERAL PROVISIONS

27 Revised Law

28 Sec. 2701.001. ABSTRACT OF TITLE DISTINGUISHED;
29 PROHIBITION ON REGULATION OF ABSTRACT OF TITLE. (a) In this
30 section, "commitment for title insurance" means a title insurance
31 form under which a title insurance company offers to issue a title
32 insurance policy subject to stated exceptions, requirements, and
33 terms. The term includes a mortgagee title policy binder on an
34 interim construction loan.

35 (b) A commitment for title insurance constitutes a
36 statement of the terms and conditions on which a title insurance

1 company is willing to issue its policy. A title insurance policy or
2 other title insurance form constitutes a statement of the terms and
3 conditions of the indemnity under the policy or form.

4 (c) An abstract of title prepared from an abstract plant for
5 a chain of title to real property described in the abstract of title
6 is not title insurance, a commitment for title insurance, or any
7 other title insurance form. A commitment for title insurance,
8 title insurance policy, or other title insurance form is not an
9 abstract of title.

10 (d) The commissioner may not adopt rules relating to
11 abstracts of title. (V.T.I.C. Art. 9.07B.)

12 Source Law

13 Art. 9.07B. (a) An abstract of title prepared
14 from an abstract plant for a chain of title of real
15 property described in the abstract of title is not
16 title insurance, a commitment for title insurance, or
17 any other title insurance form.

18 (b) The Board may not adopt regulations relating
19 to abstracts of title.

20 (c) A "commitment for title insurance" means a
21 title insurance form that offers to issue a title
22 policy subject to stated exceptions, requirements, and
23 terms. The term includes a mortgagee title policy
24 binder on an interim construction loan. The
25 commitment, binder, title policy, or other insurance
26 form is not an abstract of title. The commitment or
27 binder constitutes a statement of the terms and
28 conditions on which the title insurance company is
29 willing to issue its policy. The title insurance
30 policy or other insurance form constitutes a statement
31 of the terms and conditions of the indemnity under the
32 title insurance policy or other form.

33 Revisor's Note

34 (1) Section (b), V.T.I.C. Article 9.07B,
35 prohibits the "Board," meaning the State Board of
36 Insurance, from adopting certain "regulations."
37 Chapter 685, Acts of the 73rd Legislature, Regular
38 Session, 1993, abolished the State Board of Insurance
39 and transferred its rulemaking functions to the
40 commissioner of insurance. Section 31.001, Insurance
41 Code, defines "commissioner" for purposes of this code
42 and the other insurance laws of this state to mean the
43 commissioner of insurance. In this section, the

1 reference to the board has been changed to
2 "commissioner." The revised law substitutes the term
3 "rules" for "regulations" because under Section
4 311.005(5), Government Code (Code Construction Act),
5 applicable to the revised law, a rule includes a
6 regulation, and "rule" is the more commonly used term.

7 (2) Section (c), V.T.I.C. Article 9.07B, refers
8 to a "commitment, binder, title policy, or other
9 insurance form." The reference to "binder" is omitted
10 from the revised law as unnecessary in this context
11 because the term refers to a mortgagee title policy
12 binder on an interim construction loan, and that
13 section defines "commitment for title insurance" to
14 include such a binder.

15 (3) Section (c), V.T.I.C. Article 9.07B, refers
16 to a "commitment, binder, title policy, or other
17 insurance form" and a "title insurance policy or other
18 insurance form." The revised law substitutes "other
19 title insurance form" for "other insurance form"
20 because it is clear from the context that the type of
21 form referenced is a title insurance form.

22 Revised Law

23 Sec. 2701.002. CONSTRUCTION OF CHAPTER 39, BUSINESS &
24 COMMERCE CODE. Chapter 39, Business & Commerce Code, is a consumer
25 protection law when construed in connection with a title insurance
26 policy issued in this state. (V.T.I.C. Art. 9.50.)

27 Source Law

28 Art. 9.50. Chapter 39, Business & Commerce Code,
29 shall be deemed and considered a consumer protection
30 law when construed in connection with any policy of
31 title insurance issued in this state.

32 CHAPTER 2702. CLOSING AND SETTLEMENT

33 SUBCHAPTER A. INSURED CLOSING AND SETTLEMENT LETTERS

34 Sec. 2702.001. INSURED CLOSING AND SETTLEMENT LETTER:

35 LOANS 1647

1 Sec. 2702.002. INSURED CLOSING AND SETTLEMENT LETTER:
2 CERTAIN BUYERS OR SELLERS 1649
3 Sec. 2702.003. EFFECT OF FAILURE TO ISSUE INSURED CLOSING
4 AND SETTLEMENT LETTER 1650
5 [Sections 2702.004-2702.050 reserved for expansion]
6 SUBCHAPTER B. UNIFORM CLOSING AND SETTLEMENT STATEMENTS
7 Sec. 2702.051. APPLICABILITY 1651
8 Sec. 2702.052. DUTY TO PRESCRIBE UNIFORM CLOSING AND
9 SETTLEMENT STATEMENT FORMS 1652
10 Sec. 2702.053. CONTENT OF CLOSING AND SETTLEMENT
11 STATEMENT 1654
12 Sec. 2702.054. USE OF ALTERNATE SETTLEMENT STATEMENT FORM
13 PERMITTED 1655
14 [Sections 2702.055-2702.100 reserved for expansion]
15 SUBCHAPTER C. ADVANCE DISCLOSURE OF CLOSING AND
16 SETTLEMENT COSTS IN TRANSACTIONS INVOLVING
17 RESIDENTIAL REAL PROPERTY
18 Sec. 2702.101. APPLICABILITY 1655
19 Sec. 2702.102. DUTY TO PROVIDE ADVANCE DISCLOSURE OF CLOSING
20 AND SETTLEMENT COSTS 1655
21 Sec. 2702.103. TITLE INSURANCE COMPANY OR TITLE INSURANCE
22 AGENT NOT SUBJECT TO REQUIREMENTS
23 APPLICABLE TO LENDERS 1657
24 CHAPTER 2702. CLOSING AND SETTLEMENT
25 SUBCHAPTER A. INSURED CLOSING AND SETTLEMENT LETTERS
26 Revised Law
27 Sec. 2702.001. INSURED CLOSING AND SETTLEMENT LETTER:
28 LOANS. (a) On request, a title insurance company may issue insured
29 closing and settlement letters in connection with the closing and
30 settlement by a title insurance agent or direct operation of loans
31 relating to real property located in this state.
32 (b) Insured closing and settlement letters must be issued in
33 the form prescribed by the commissioner.
34 (c) A title insurance company may not impose a charge for

1 issuing insured closing and settlement letters under this section.
2 (V.T.I.C. Art. 9.49, Sec. (a) (part).)

3 Source Law

4 Art. 9.49. (a) Title insurance companies
5 operating under the provisions of this chapter are
6 hereby expressly authorized and empowered to issue
7 upon request on real property transactions in this
8 state at no charge whatever insured closing and
9 settlement letters, in the form prescribed by the
10 board, in connection with the closing and settlement
11 of loans by a title insurance agent or direct operation
12 for any title insurance company operating under the
13 provisions of this chapter. Only the form prescribed
14 by the board shall be used in issuing such insured
15 closing and settlement letters. . . .

16 Revisor's Note

17 (1) Section (a), V.T.I.C. Article 9.49,
18 authorizes title insurance companies "operating under
19 the provisions of this chapter," meaning V.T.I.C.
20 Chapter 9, which is revised in this code as this title,
21 to take certain actions with respect to real property
22 transactions in this state. The revised law omits the
23 quoted language as unnecessary because under V.T.I.C.
24 Article 9.02, revised as Section 2501.003 of this
25 code, "title insurance company" is defined for
26 purposes of this title in a manner that means and
27 includes only those companies operating under this
28 title.

29 (2) Section (a), V.T.I.C. Article 9.49, refers
30 to "real property transactions in this state" and "the
31 closing and settlement of loans." The revised law
32 refers to "the closing and settlement . . . of loans
33 relating to real property located in this state" to
34 conform to the terminology of Section (b), V.T.I.C.
35 Article 9.49, revised in pertinent part as Section
36 2702.002, which applies to a real property transaction
37 involving real property "located" in this state. It is
38 clear from the context that Section (a), V.T.I.C.
39 Article 9.49, applies only to transactions involving

1 real property "located" in this state.

2 (3) Section (a), V.T.I.C. Article 9.49, refers
3 to the "board," meaning the State Board of Insurance.
4 Chapter 685, Acts of the 73rd Legislature, Regular
5 Session, 1993, abolished the State Board of Insurance
6 and transferred its functions to the commissioner of
7 insurance and the Texas Department of Insurance, as
8 appropriate. Throughout this chapter, references to
9 the board have been changed appropriately.

10 (4) Section (a), V.T.I.C. Article 9.49, refers
11 to a direct operation "for any title insurance
12 company." The revised law omits the quoted language as
13 unnecessary because under V.T.I.C. Article 9.02,
14 revised as Section 2501.003 of this code, "direct
15 operation" is defined as an operation "of a title
16 insurance company."

17 Revised Law

18 Sec. 2702.002. INSURED CLOSING AND SETTLEMENT LETTER:
19 CERTAIN BUYERS OR SELLERS. (a) On written request, a title
20 insurance company may issue to the buyer or seller of real property
21 located in this state, the sales price of which exceeds the maximum
22 covered claim specified by Chapter 2602, an insured closing and
23 settlement letter in connection with the closing and settlement of
24 the transaction by a title insurance agent or direct operation.
25 Only the title insurance company that is to issue an owner title
26 insurance policy in connection with the transaction may issue the
27 insured closing and settlement letter.

28 (b) An insured closing and settlement letter must be issued:

29 (1) at or before closing; and

30 (2) in the form and manner prescribed by the
31 commissioner.

32 (c) The commissioner may adopt a charge for the issuance of
33 an insured closing and settlement letter under this section and
34 prescribe the form and manner in which the charge must be made.

1 (V.T.I.C. Art. 9.49, Sec. (b) (part).)

2 Source Law

3 (b) When an owner policy of title insurance is
4 to be issued in connection with a real property
5 transaction involving real property located in this
6 state, only the title insurance company issuing that
7 owner policy is hereby expressly authorized and
8 empowered, at or before closing, to issue, upon
9 written request, to the buyer or seller of the real
10 property in connection with such closing and
11 settlement by a title insurance agent or direct
12 operation an insured closing and settlement letter,
13 provided that the sale price of the real property
14 exceeds the guaranty amount specified in Article 9.48
15 of this Insurance Code. Only the form of letter and
16 the manner of issuance prescribed by the board shall be
17 used in issuing such buyer's or seller's insured
18 closing and settlement letters. . . . The board may
19 promulgate a charge, if any, to be made in the form and
20 manner prescribed by the board for the issuance of each
21 insured closing and settlement letter.

22 Revisor's Note

23 Section (b), V.T.I.C. Article 9.49, refers to the
24 "guaranty amount" specified in V.T.I.C. Article 9.48,
25 which is revised as Chapter 2602 of this code. The
26 revised law substitutes the term "maximum covered
27 claim" to conform to the terminology used in V.T.I.C.
28 Article 9.48.

29 Revised Law

30 Sec. 2702.003. EFFECT OF FAILURE TO ISSUE INSURED CLOSING
31 AND SETTLEMENT LETTER. The failure of a title insurance company to
32 issue an insured closing and settlement letter does not affect the
33 company's liability under an issued title insurance policy.
34 (V.T.I.C. Art. 9.49, Secs. (a) (part), (b) (part).)

35 Source Law

36 (a) . . . The liability of the title insurance
37 company under a policy of title insurance that is
38 issued shall not be changed or altered by the failure
39 of the title insurance company to issue such insured
40 closing and settlement letters.

41 (b) . . . The liability of the title insurance
42 company under any issued policy of title insurance
43 shall not be changed or altered by the failure of the
44 title insurance company to issue the authorized
45 buyer's or seller's insured closing and settlement
46 letters. . . .

47 Revisor's Note

48 V.T.I.C. Article 9.49 provides that the liability

1 of a title insurance company under an issued title
2 insurance policy is not "changed or altered" by the
3 company's failure to issue closing and settlement
4 letters. The revised law provides that such a failure
5 does not "affect" the company's liability because
6 "affect" has the same meaning as "changed or altered"
7 and is more concise.

8 [Sections 2702.004-2702.050 reserved for expansion]

9 SUBCHAPTER B. UNIFORM CLOSING AND SETTLEMENT STATEMENTS

10 Revised Law

11 Sec. 2702.051. APPLICABILITY. This subchapter does not
12 apply to the closing or settlement of:

13 (1) a residential real property transaction regulated
14 by the Real Estate Settlement Procedures Act of 1974 (Pub. L. No.
15 93-533); or

16 (2) a real property transaction if the closing or
17 settlement is not actually handled by:

18 (A) a title insurance company, a title insurance
19 agent, or an attorney for a title insurance company or title
20 insurance agent; or

21 (B) a representative of a title insurance
22 company, a title insurance agent, or an attorney for a title
23 insurance company or title insurance agent. (V.T.I.C. Art. 9.53
24 (part).)

25 Source Law

26 Art. 9.53. . . .

27 The provisions of this Article 9.53 of this
28 Chapter 9 shall not apply to the settlement or closing
29 of any residential real estate transaction regulated
30 by the provisions of the Real Estate Settlement
31 Procedures Act of 1974 (Public Law 93-533).

32 The provisions of this Article 9.53 of this
33 Chapter 9 shall not apply to a settlement or closing if
34 neither a title insurance company, a title insurance
35 agent, an attorney for a title insurance company or
36 title insurance agent, nor a representative of the
37 title insurance company, title insurance agent or
38 attorney for a title insurance company or title
39 insurance agent has actually handled the closing or
40 settlement of such real estate transaction.

1 Revised Law

2 Sec. 2702.052. DUTY TO PRESCRIBE UNIFORM CLOSING AND
3 SETTLEMENT STATEMENT FORMS. (a) The department, after notice and
4 hearing, shall prescribe uniform closing and settlement statement
5 forms to be used in connection with the closing and settlement of a
6 transaction involving:

7 (1) the conveyance or mortgage of real property; and

8 (2) the issuance of a title insurance policy by a title
9 insurance company or title insurance agent.

10 (b) The department may prescribe separate forms under this
11 section for transactions involving improved residential real
12 property and for all other real property transactions.

13 (c) The department shall design the forms under this section
14 to enable each party to the transaction to be provided with a dual
15 or separate form identifying only the charges made to that party.
16 (V.T.I.C. Art. 9.53 (part).)

17 Source Law

18 Art. 9.53. On or prior to January 1, 1976, the
19 board, after notice and hearing, shall prescribe
20 uniform settlement and closing statement forms to be
21 used in connection with the settlement and closing of
22 any conveyance or mortgaging of real estate in which
23 transaction a title insurance policy is issued by any
24 title insurance company or title insurance agent. The
25 board is specifically authorized to establish separate
26 forms for transactions involving improved residential
27 real property and for all other real property
28 transactions. The forms prescribed by the board shall
29 be designed so that dual forms or separate forms
30 provided for each party to the transaction identifying
31 only the charges made to such party may be used at any
32 settlement or closing. . . .

33 Revisor's Note

34 V.T.I.C. Article 9.53 requires the State Board of
35 Insurance to prescribe uniform settlement and closing
36 statement forms "[o]n or prior to January 1, 1976."
37 The revised law omits the reference to the deadline for
38 prescribing the forms because that provision is
39 executed.

40 Revised Law

41 Sec. 2702.053. CONTENT OF CLOSING AND SETTLEMENT

1 STATEMENT. (a) Each closing and settlement statement provided to
2 a party to a transaction described by Section 2702.052(a) must
3 state the name of any person receiving any amount from that party.

4 (b) Notwithstanding Subsection (a), the title insurance
5 company or title insurance agent is required to include in the
6 closing and settlement statement only those items of disbursement
7 that are actually disbursed by the company or agent.

8 (c) If an attorney, other than a full-time employee of the
9 title insurance company or title insurance agent, examines a title
10 or provides any closing or settlement services, the closing and
11 settlement statement must include:

12 (1) the amount of the fee for the services, shown as
13 included in the premium; and

14 (2) the name of the attorney or, if applicable, the
15 name of the firm to which the fee was paid.

16 (d) The closing and settlement statement must conspicuously
17 and clearly itemize the charges imposed on the party in connection
18 with the closing and settlement.

19 (e) If a charge for title insurance is made to the party, the
20 closing and settlement statement must state whether the title
21 insurance premium included in the charge covers the mortgagee's
22 interest in the real property, the borrower's interest, or both.

23 (V.T.I.C. Art. 9.53 (part).)

24 Source Law

25 Art. 9.53. . . .

26 Every such settlement and closing statement
27 furnished to a party to the transaction shall state
28 thereon the name of any person, firm, or corporation
29 receiving any sum from such party to the settlement or
30 closing. The title insurance company and the title
31 insurance agent, however, shall be required to include
32 within the closing and settlement statement only those
33 items of disbursement as are actually disbursed by the
34 title insurance company or the title insurance agent.
35 If a title is examined or any closing or settlement
36 services rendered by an attorney, other than a
37 full-time employee of either the title insurance
38 company or the title insurance agent, the amount of
39 such fee (shown as included in the premium) and the
40 name of the attorney (which may be expressed by the
41 name of the firm, if applicable) to whom such fee was
42 paid shall be shown thereon. Such form shall also
43 conspicuously and clearly itemize the charges imposed

1 upon such party in connection with the settlement and
2 closing. If a charge for title insurance is made to
3 such party, the form shall state whether the title
4 insurance premium included in such charges covers or
5 insures the mortgagee's interest in the property, the
6 borrower's interest, or both. . . .

7 Revisor's Note

8 V.T.I.C. Article 9.53 refers to a "person, firm,
9 or corporation." V.T.I.C. Article 9.02, revised as
10 Section 2501.003 of this code, defines "person" for
11 purposes of this title to include "individuals,
12 corporations, associations, partnerships and trusts."
13 Because the substance of the definition of "person"
14 includes both a "firm" and a "corporation," the
15 revised law omits the references to those terms as
16 unnecessary.

17 Revised Law

18 Sec. 2702.054. USE OF ALTERNATE SETTLEMENT STATEMENT FORM
19 PERMITTED. A title insurance company or title insurance agent may
20 use the uniform settlement statement form prepared under the Real
21 Estate Settlement Procedures Act of 1974 (Pub. L. No. 93-533)
22 instead of the uniform closing and settlement statement form
23 prescribed by the department under this subchapter. (V.T.I.C.
24 Art. 9.53 (part).)

25 Source Law

26 Art. 9.53. . . .
27 Any title insurance company or any title
28 insurance agent may at its election use the uniform
29 closing statement prepared under the provisions of the
30 Real Estate Settlement Procedures Act of 1974 (Public
31 Law 93-533) in lieu of the uniform closing statement
32 prescribed by the board. . . .

33 Revisor's Note

34 V.T.I.C. Article 9.53 refers to the "uniform
35 closing statement" prepared under the Real Estate
36 Settlement Procedures Act of 1974 (Pub. L. No.
37 93-533). The revised law refers to the "uniform
38 settlement statement form" prepared under that act to
39 conform to the terminology of Section 4, Real Estate
40 Settlement Procedures Act of 1974 (Pub. L. No.

1 93-533).

2 [Sections 2702.055-2702.100 reserved for expansion]

3 SUBCHAPTER C. ADVANCE DISCLOSURE OF CLOSING AND

4 SETTLEMENT COSTS IN TRANSACTIONS INVOLVING

5 RESIDENTIAL REAL PROPERTY

6 Revised Law

7 Sec. 2702.101. APPLICABILITY. This subchapter does not
8 apply to the closing or settlement of a real property transaction if
9 the closing or settlement is not actually handled by:

10 (1) a title insurance company, a title insurance
11 agent, or an attorney for a title insurance company or title
12 insurance agent; or

13 (2) a representative of a title insurance company, a
14 title insurance agent, or an attorney for a title insurance company
15 or title insurance agent. (V.T.I.C. Art. 9.54 (part).)

16 Source Law

17 Art. 9.54. . . .

18 The provisions of this Article 9.54 of this
19 Chapter 9 shall not apply to a settlement or closing if
20 neither a title insurance company, a title insurance
21 agent, an attorney for a title insurance company or
22 title insurance agent, nor a representative of the
23 title insurance company, title insurance agent or
24 attorney for a title insurance company or title
25 insurance agent has actually handled the closing or
26 settlement of such real estate transaction.

27 Revised Law

28 Sec. 2702.102. DUTY TO PROVIDE ADVANCE DISCLOSURE OF
29 CLOSING AND SETTLEMENT COSTS. (a) Except as provided by
30 Subsection (c), on the written request of the buyer, seller, or
31 borrower before the closing and settlement of a transaction
32 involving improved residential real property, a title insurance
33 company or title insurance agent shall, in connection with the
34 issuance of any kind of title insurance policy guaranteeing a lien
35 on or the title to the property, provide to the requesting party an
36 itemized disclosure of each charge to be made to that party that
37 arises in connection with the closing and settlement.

38 (b) The itemized disclosure must be provided on a closing

1 and settlement statement form prescribed or permitted under
2 Subchapter B.

3 (c) The title insurance company or title insurance agent is
4 required to provide the itemized disclosure only to the extent that
5 information is available concerning each charge to be made to the
6 party. If information concerning a charge is not available, the
7 title insurance company or title insurance agent shall:

8 (1) make a notation that the charge is to be made but
9 that the information is not available or that the amount shown is an
10 estimate of the charge; and

11 (2) advise the party in writing as to the identity of
12 the person or organization responsible for the charge. (V.T.I.C.
13 Art. 9.54 (part).)

14 Source Law

15 Art. 9.54. Every title insurance company and
16 every title insurance agent licensed to do business in
17 Texas under the provisions of this Chapter 9 shall, in
18 connection with the issuance of any type of title
19 policy guaranteeing either a lien upon or the title to
20 improved residential property, upon written request of
21 the buyer, seller, or borrower prior to settlement and
22 closing, furnish to any such requesting party to such
23 transaction an itemized disclosure in writing, to the
24 extent that the information is available, each charge
25 to be made to such party, arising in connection with
26 such closing and settlement, upon any standard real
27 estate settlement and closing form developed,
28 prescribed or authorized under Article 9.53 of this
29 chapter. If information is not available concerning
30 any item or items of charges to be made to such party,
31 proper notation shall be made that a charge is to be
32 made, but the information is not available or that the
33 amount shown is an estimate of such charge. Such
34 person shall be advised in writing as to the identity
35 of the person or organization responsible for such
36 charges to be made for which an estimate has been made
37 or for which notation has been made that the
38 information is not available. . . .

39 Revisor's Note

40 (1) V.T.I.C. Article 9.54 requires each title
41 insurance company and each title insurance agent
42 "licensed to do business in Texas under the provisions
43 of this Chapter 9," which is revised in this code as
44 this title, to provide on request of a party to a
45 transaction involving improved residential real

1 property an itemized disclosure of each charge to be
2 made to the party that arises in connection with the
3 closing and settlement of the transaction. The
4 revised law omits the quoted language as unnecessary
5 because it is clear from the context that the provision
6 applies only to title insurance companies and title
7 insurance agents authorized or licensed to engage in
8 business in this state.

9 (2) V.T.I.C. Article 9.54 refers to
10 "residential property." The revised law substitutes a
11 reference to "residential real property" because that
12 is the term defined in V.T.I.C. Article 9.02, revised
13 as Section 2501.003 of this code.

14 (3) V.T.I.C. Article 9.54 requires each title
15 insurance company and each title insurance agent to
16 provide on request of a party to a transaction
17 involving improved residential real property an
18 itemized disclosure of certain charges "in writing" on
19 a closing and settlement statement "form." The
20 revised law omits as unnecessary the requirement that
21 the itemized disclosure be "in writing" because a
22 disclosure that is made on a "form" is necessarily "in
23 writing."

24 Revised Law

25 Sec. 2702.103. TITLE INSURANCE COMPANY OR TITLE INSURANCE
26 AGENT NOT SUBJECT TO REQUIREMENTS APPLICABLE TO
27 LENDERS. (a) Notwithstanding Section 2702.102, a title insurance
28 company or title insurance agent is not required to disclose a cost
29 or charge that a lender is required by law to disclose to a party.

30 (b) Section 2702.102 does not impose on a title insurance
31 company or title insurance agent any obligation imposed on a lender
32 by the Real Estate Settlement Procedures Act of 1974 (Pub. L. No.
33 93-533). (V.T.I.C. Art. 9.54 (part).)

1 Source Law

2 Art. 9.54. . . .

3 Provided, however, that the title insurance
4 company or title insurance agent providing the
5 disclosures of items of charge shall not be required to
6 disclose costs or charges which the lender is required
7 by any law to disclose to such party. Nothing
8 contained in this Article 9.54 shall be deemed or
9 construed as placing upon any title insurance company
10 or title insurance agent any of the obligations
11 imposed upon lenders by reason of the Federal Real
12 Estate Settlement Procedures Act of 1974 (Public Law
13 93-533). . . .

14 CHAPTER 2703. POLICY FORMS AND PREMIUM RATES

15 SUBCHAPTER A. GENERAL PROVISIONS

16 Sec. 2703.001. COMPLIANCE WITH TITLE AND RULES 1659
17 Sec. 2703.002. USE OF FORMS IN GENERAL 1661
18 Sec. 2703.003. PAYMENT OF PREMIUMS 1661

19 [Sections 2703.004-2703.050 reserved for expansion]

20 SUBCHAPTER B. POLICY PROVISIONS

21 Sec. 2703.051. CERTAIN PROVISIONS REQUIRED 1662
22 Sec. 2703.052. DUTY OF TITLE INSURANCE COMPANY 1662
23 Sec. 2703.053. ESTABLISHMENT OF STANDARDS AND SCHEDULES . . . 1664
24 Sec. 2703.054. AUTHORITY OF COMMISSIONER IN IMPLEMENTING

25 SUBCHAPTER 1664

26 [Sections 2703.055-2703.100 reserved for expansion]

27 SUBCHAPTER C. POLICY FORMS FOR RESIDENTIAL REAL PROPERTY

28 Sec. 2703.101. POLICY FORMS FOR RESIDENTIAL REAL
29 PROPERTY 1665

30 [Sections 2703.102-2703.150 reserved for expansion]

31 SUBCHAPTER D. FIXING AND PROMULGATING PREMIUM RATES

32 Sec. 2703.151. FIXING AND PROMULGATING PREMIUM RATES. 1667
33 Sec. 2703.152. FACTORS CONSIDERED IN FIXING PREMIUM RATES . . 1668
34 Sec. 2703.153. COLLECTION OF DATA FOR FIXING PREMIUM
35 RATES 1669

36 [Sections 2703.154-2703.200 reserved for expansion]

37 SUBCHAPTER E. PROCEDURES REGARDING PREMIUM RATES,
38 POLICY FORMS, AND OTHER RELATED MATTERS

39 Sec. 2703.201. HEARING REQUIRED FOR FIXING PREMIUM RATE . . . 1669
40 Sec. 2703.202. HEARING REQUIRED FOR CHANGE IN PREMIUM

1 RATE 1669

2 Sec. 2703.203. BIENNIAL HEARING. 1670

3 Sec. 2703.204. ADMISSION AS PARTY TO BIENNIAL HEARING 1670

4 Sec. 2703.205. PHASES OF BIENNIAL HEARING 1671

5 Sec. 2703.206. COMMISSIONER AUTHORITY TO HOLD HEARINGS AS

6 NECESSARY 1672

7 Sec. 2703.207. NOTICE OF CERTAIN HEARINGS 1672

8 Sec. 2703.208. ADDITIONS OR AMENDMENTS TO MANUAL 1673

9 CHAPTER 2703. POLICY FORMS AND PREMIUM RATES

10 SUBCHAPTER A. GENERAL PROVISIONS

11 Revised Law

12 Sec. 2703.001. COMPLIANCE WITH TITLE AND RULES. (a) This

13 section applies to a corporation organized under this title, a

14 foreign corporation, and, to the extent that the corporation is

15 engaged in the business of title insurance, a corporation organized

16 under another law, including:

17 (1) Subdivision 57, Article 1302, Revised Statutes,

18 before repeal of that statute; and

19 (2) Chapter 861.

20 (b) A corporation operates in this state under the control

21 and supervision of the commissioner and under uniform rules adopted

22 by the commissioner relating to:

23 (1) forms of policies and underwriting contracts;

24 (2) premiums for those policies and contracts; and

25 (3) underwriting standards and practices.

26 (c) With respect to real property located in this state, a

27 corporation may not issue any kind of title insurance coverage, any

28 kind of guarantee, or reinsurance of a risk assumed under a title

29 insurance policy, except as provided by Section 2551.305(a), unless

30 the corporation is authorized to engage in the business of title

31 insurance under this title and otherwise complies with this title.

32 In engaging in the business of title insurance with respect to real

33 property located in this state, the corporation shall comply with

34 this title and rules described by Subsection (b), including when:

1 (1) issuing any kind of title insurance policy or an
2 underwriting contract;

3 (2) reinsuring any portion of a risk assumed under a
4 title insurance policy; and

5 (3) deleting a title insurance policy exclusion.

6 (d) Title insurance coverage, reinsurance, or a guarantee
7 issued in violation of Subsection (c) is invalid. (V.T.I.C.
8 Art. 9.07, Sec. (a) (part).)

9 Source Law

10 Art. 9.07. (a) Corporations organized under
11 this Chapter, as well as foreign corporations and
12 those created under Subdivision 57, Article 1302, of
13 the Revised Civil Statutes of 1925 before the repeal of
14 that statute, or under Chapter 8 of this Code, or any
15 other law insofar as the business of either may be the
16 business of title insurance, shall operate in Texas
17 under the control and supervision and under such
18 uniform rules and regulations as to forms of policies
19 and underwriting contracts and premiums therefor, and
20 such underwriting standards and practices as may be
21 prescribed by the commissioner; and no Texas or
22 foreign corporation, whether incorporated under this
23 Chapter or any other law of the State of Texas, shall
24 be permitted to conduct the business of title
25 insurance, to issue any title policy of any character,
26 or underwriting contract, to delete any policy
27 exclusion or to reinsure any portion of the risk
28 assumed by any title policy, on Texas real property
29 other than under this Chapter and under such rules and
30 regulations. No policy of title insurance, title
31 insurance coverage, reinsurance of any risk assumed
32 under any policy of title insurance, or any guarantee
33 of any character made when insuring Texas titles shall
34 be issued or valid unless written by a corporation
35 complying with the provisions of and authorized or
36 qualified under this Chapter, except as is provided in
37 Article 9.19D. . . .

38 Revisor's Note

39 (1) Section (a), V.T.I.C. Article 9.07, refers
40 to "rules and regulations." Throughout this chapter,
41 the revised law omits the reference to "regulations"
42 in that context because under Section 311.005(5),
43 Government Code (Code Construction Act), a rule is
44 defined to include a regulation. That definition
45 applies to the revised law.

46 (2) Section (a), V.T.I.C. Article 9.07,
47 provides that "[n]o policy of title insurance, title

1 insurance coverage, reinsurance of any risk assumed
2 under any policy of title insurance, or any guarantee
3 . . . shall be issued or valid unless written" by
4 certain corporations. The revised law omits as
5 unnecessary the reference to "policy of title
6 insurance" because that term is included within the
7 meaning of "title insurance coverage." The revised
8 law omits as unnecessary the reference to "written"
9 because the concept of "written" is implicit in the
10 concept of "issued."

11 (3) Section (a), V.T.I.C. Article 9.07, refers
12 to a corporation "authorized or qualified under this
13 Chapter," meaning V.T.I.C. Chapter 9, which is revised
14 in this code as this title. The revised law omits the
15 reference to "qualified" because under this code a
16 corporation is issued a certificate of authority to
17 engage in business in this state.

18 Revised Law

19 Sec. 2703.002. USE OF FORMS IN GENERAL. A title insurance
20 company or title insurance agent may not use a form required under
21 this title to be prescribed or approved until the commissioner has
22 prescribed or approved the form. (V.T.I.C. Art. 9.07, Sec. (a)
23 (part).)

24 Source Law

25 (a) . . . Under no circumstances may any title
26 insurance company or title insurance agent use any
27 form which is required under the provisions of this
28 Chapter 9 to be promulgated or approved until the same
29 shall have been so promulgated or approved by the
30 commissioner.

31 Revised Law

32 Sec. 2703.003. PAYMENT OF PREMIUMS. The premium for a
33 title insurance policy or for another form prescribed or approved
34 by the commissioner shall be paid in the due and ordinary course of
35 business. (V.T.I.C. Art. 9.07, Sec. (b) (part).)

1 report to a title insurance company made by an insured after a title
2 insurance policy has been issued that a lien, encumbrance, or title
3 defect exists that is not excepted under the policy or otherwise
4 excluded from coverage, the company shall promptly investigate to
5 determine whether the lien or encumbrance is valid and not barred by
6 statute or other law.

7 (b) A title insurance company that concludes that a valid
8 lien or encumbrance that is not barred by statute or other law
9 exists or that a title defect exists shall:

10 (1) institute all necessary legal proceedings to clear
11 the title to the property;

12 (2) indemnify the insured according to the terms of
13 the policy;

14 (3) reinsure at current value the title to the
15 property without making exception to the lien, encumbrance, or
16 defect or indemnify another insurer for reinsuring the title
17 without making exception to the lien, encumbrance, or defect;

18 (4) secure a release of the lien, encumbrance, or
19 defect; or

20 (5) take a combination of the actions described by
21 this subsection. (V.T.I.C. Art. 9.57, Sec. (b).)

22 Source Law

23 (b) If after the policy of title insurance has
24 been issued, the insured reports to the title
25 insurance company that a lien or encumbrance exists
26 which is not excepted under the policy or excluded from
27 coverage or that there is a defect in the title
28 likewise not excepted under the policy or excluded
29 from coverage:

30 (1) the title insurance company will
31 promptly investigate to determine if that lien or
32 encumbrance is valid and not barred by law or statute;
33 and

34 (2) if the title insurance company
35 concludes that a valid lien or encumbrance, not barred
36 by law or statute, exists or that a title defect
37 exists, the title insurance company will take one of
38 the following actions:

39 (A) institute all necessary legal
40 proceedings to clear the title to the property;

41 (B) indemnify the insured pursuant to
42 the terms of the policy;

43 (C) reinsure at current value the
44 title to the property without making exception to the
45 lien, encumbrance, or defect or indemnify another

1 insurer for reinsuring the title without making
2 exception to the lien, encumbrance, or defect;
3 (D) secure a release of the
4 encumbrance, lien, or defect; or
5 (E) effect a combination of
6 Subdivisions (A) through (D) of this subsection.

7 Revised Law

8 Sec. 2703.053. ESTABLISHMENT OF STANDARDS AND
9 SCHEDULES. The commissioner by rule shall establish standards and
10 time schedules for implementing and handling claims by title
11 insurance companies in accordance with this subchapter. (V.T.I.C.
12 Art. 9.57, Sec. (d).)

13 Source Law

14 (d) The State Board of Insurance shall adopt
15 rules and regulations establishing standards and time
16 schedules for implementing and handling claims by
17 title insurance companies as provided in this article.

18 Revised Law

19 Sec. 2703.054. AUTHORITY OF COMMISSIONER IN IMPLEMENTING
20 SUBCHAPTER. (a) The commissioner may adopt, by amendment to an
21 owner title insurance policy or by separate endorsement to an owner
22 title insurance policy, language to implement this subchapter in a
23 manner consistent with the terms, provisions, conditions, and
24 stipulations of the policy or the exceptions to coverage contained
25 in the schedules to the policy.

26 (b) This subchapter does not prohibit the commissioner from
27 adopting for use in this state one or more policies in a simplified,
28 generally more understandable, and usable form. (V.T.I.C. Art.
29 9.57, Sec. (c).)

30 Source Law

31 (c) The State Board of Insurance may promulgate,
32 by amendment to the Owner Policy of Title Insurance or
33 by separate endorsement to the Owner Policy of Title
34 Insurance, language to carry out this article in a
35 manner consistent with the terms, provisions,
36 conditions, and stipulations of the policy or the
37 exceptions to coverage contained in the schedules to
38 the policy. Nothing in this article prohibits the
39 State Board of Insurance from adopting for use in this
40 state a policy or policies in a simplified, generally
41 more understandable, and usable form.

42 [Sections 2703.055-2703.100 reserved for expansion]

1 SUBCHAPTER C. POLICY FORMS FOR RESIDENTIAL REAL PROPERTY

2 Revised Law

3 Sec. 2703.101. POLICY FORMS FOR RESIDENTIAL REAL
4 PROPERTY. (a) The commissioner shall prescribe an owner title
5 insurance policy form to be issued in connection with a transaction
6 involving residential real property in this state.

7 (b) A title insurance company or title insurance agent shall
8 use the form prescribed by the commissioner in issuing to an
9 individual an owner title insurance policy relating to residential
10 real property in this state.

11 (c) Unless authorized by rule adopted by the commissioner,
12 an insurer may not enter into a contract or other agreement
13 concerning an individual title insurance policy if the contract or
14 other agreement is not expressed in the policy. A contract or
15 agreement prohibited by this subsection is void.

16 (d) An endorsement prescribed by the commissioner may be
17 attached to the title insurance policy form as authorized by rule
18 adopted by the commissioner.

19 (e) The commissioner may not prescribe an owner title
20 insurance policy form for residential real property or an
21 endorsement to the policy if the policy form or endorsement is not
22 written in plain language. For purposes of this subsection, a
23 policy form or endorsement is written in plain language if it
24 achieves the minimum score established by the commissioner on the
25 Flesch reading ease test or an equivalent test selected by the
26 commissioner or, at the commissioner's option, if it conforms to
27 the language requirements in a National Association of Insurance
28 Commissioners model act relating to plain language. This
29 subsection does not apply to policy language required by state or
30 federal law.

31 (f) For an owner title insurance policy on residential real
32 property that is issued to an individual, the commissioner may
33 adopt coverages that insure against ad valorem taxes, including
34 penalties and interest, to be paid with respect to the property for

1 a previous tax year:

2 (1) that are delinquent on the effective date of the
3 policy because of sale, diversion, or change of use, unless
4 excluded because the insured has actual knowledge of the delinquent
5 taxes; or

6 (2) that result from an exemption granted to a
7 previous owner of the property under Section 11.13, Tax Code, or
8 from an improvement not assessed for a previous tax year, unless
9 excluded because the insured has actual knowledge of the taxes.
10 (V.T.I.C. Art. 9.07A.)

11 Source Law

12 Art. 9.07A. (a) The board shall adopt an owner
13 policy form to be issued in connection with
14 transactions involving residential real estate in this
15 state.

16 (b) A title insurance company or title insurance
17 agent shall use a form adopted by the commissioner
18 under this article in issuing owner policies to
19 natural persons relating to residential real property
20 in this state.

21 (c) An insurer may not enter into a contract or
22 agreement concerning an individual policy that is not
23 expressed in the policy unless permitted by rules
24 adopted by the board. Such a contract or agreement is
25 void.

26 (d) Endorsements promulgated by the board may be
27 attached to the policy form, provided such an
28 endorsement is in conformity with rules adopted by the
29 board.

30 (e) The board may not adopt an owner policy form
31 for residential real property or any endorsement to
32 the policy if the policy or endorsement is not in plain
33 language. For the purposes of this subsection, a
34 policy or endorsement is written in plain language if
35 it achieves the minimum score established by the
36 commissioner on the Flesch reading ease test or an
37 equivalent test selected by the commissioner or, at
38 the option of the commissioner, if it conforms to the
39 language requirements in a National Association of
40 Insurance Commissioners model act relating to plain
41 language. This subsection does not apply to policy
42 language that is mandated by state or federal law.

43 (f) For an owner policy on residential real
44 property that is issued to a natural person, the
45 commissioner may adopt coverages that insure against:

46 (1) ad valorem taxes, including penalties
47 and interest, to be paid with respect to the property
48 for a previous tax year and that are delinquent on the
49 effective date of the policy because of sale,
50 diversion, or change of use, unless excluded because
51 the insured has actual knowledge of the delinquent
52 taxes; and

53 (2) ad valorem taxes, including penalties
54 and interest, to be paid with respect to the property
55 for a previous tax year because of an exemption granted
56 to a previous owner of the property under Section

1 11.13, Tax Code, or because of improvements not
2 assessed for a previous tax year, unless excluded
3 because the insured has actual knowledge of the taxes.

4 Revisor's Note

5 Sections (b) and (f), V.T.I.C. Article 9.07A,
6 refer to "natural persons" and "a natural person." The
7 revised law substitutes "individual" for "natural
8 person" for consistency with the terminology used in
9 this code.

10 [Sections 2703.102-2703.150 reserved for expansion]

11 SUBCHAPTER D. FIXING AND PROMULGATING PREMIUM RATES

12 Revised Law

13 Sec. 2703.151. FIXING AND PROMULGATING PREMIUM RATES. (a)
14 Except as provided by Subsection (b), the commissioner shall fix
15 and promulgate the premium rates to be charged by a title insurance
16 company or by a title insurance agent for title insurance policies
17 or for other forms prescribed or approved by the commissioner.

18 (b) The commissioner may not fix or promulgate the premium
19 rates for reinsurance between title insurance companies. Title
20 insurance companies may establish the premium rates in amounts to
21 which the companies agree.

22 (c) Except for a premium charged for reinsurance, a premium
23 may not be charged for a title insurance policy or for another
24 prescribed or approved form at a rate different than the rate fixed
25 and promulgated by the commissioner. (V.T.I.C. Art. 9.07, Sec. (b)
26 (part).)

27 Source Law

28 (b) The commissioner shall have the duty to fix
29 and promulgate the premium rates to be charged by title
30 insurance companies and title insurance agents created
31 or operating under this Chapter [for policies of title
32 insurance or other promulgated or approved forms]
33 Premium rates for reinsurance as between title
34 insurance companies qualified under this Chapter shall
35 not be fixed or promulgated by the commissioner, and
36 title insurance companies may set such premium rates
37 for reinsurance as such title insurance companies
38 shall agree upon. Under no circumstance shall any
39 premium be charged for any policy of title insurance or
40 other promulgated or approved forms different from
41 those fixed and promulgated by the commissioner,
42 except for premiums charged for reinsurance. . . .

1 Revisor's Note

2 Section (b), V.T.I.C. Article 9.07, refers to
3 title insurance companies and title insurance agents
4 "created or operating under this Chapter" and to title
5 insurance companies "qualified under this Chapter,"
6 meaning V.T.I.C. Chapter 9, which is revised in this
7 code as this title. Throughout Subchapters D and E,
8 the revised law omits the quoted language and similar
9 references, such as title insurance companies and
10 title insurance agents "authorized to do business
11 under this Chapter," as unnecessary because under
12 V.T.I.C. Article 9.02, revised in part as Section
13 2501.003 of this code, "title insurance company" and
14 "title insurance agent" are defined for purposes of
15 this title in a manner that means and includes only
16 those companies or agents created, operating,
17 qualified, or authorized under this title.

18 Revised Law

19 Sec. 2703.152. FACTORS CONSIDERED IN FIXING PREMIUM
20 RATES. (a) In fixing premium rates, the commissioner shall
21 consider all relevant income and expenses of title insurance
22 companies and title insurance agents attributable to engaging in
23 the business of title insurance in this state.

24 (b) The premium rates fixed by the commissioner must be:

- 25 (1) reasonable as to the public; and
26 (2) nonconfiscatory as to title insurance companies
27 and title insurance agents. (V.T.I.C. Art. 9.07, Sec. (b) (part).)

28 Source Law

29 (b) . . . The premium rates fixed by the
30 commissioner shall be reasonable to the public and
31 nonconfiscatory as to the title insurance companies
32 and title insurance agents. . . . In fixing the rate
33 of premiums, the commissioner shall consider all
34 relevant income and expenses of title insurance
35 companies and title insurance agents attributable to
36 Texas title insurance business.

1 Revised Law

2 Sec. 2703.153. COLLECTION OF DATA FOR FIXING PREMIUM
3 RATES. (a) Each title insurance company and title insurance agent
4 engaged in the business of title insurance in this state shall
5 submit to the department, as required by the department to collect
6 data to use to fix premium rates, all information relating to:

- 7 (1) loss experience;
8 (2) expense of operation; and
9 (3) other material matters.

10 (b) The information must be submitted in the form prescribed
11 by the department. (V.T.I.C. Art. 9.07, Sec. (b) (part).)

12 Source Law

13 (b) . . . For the purpose of collecting data on
14 which to determine the proper rates to be fixed, the
15 commissioner shall require all title insurance
16 companies and all title insurance agents operating in
17 Texas to submit such information in such form as the
18 commissioner may deem proper, all information as to
19 loss experience, expense of operation, and other
20 material matters for the commissioner's
21 consideration. . . .

22 [Sections 2703.154-2703.200 reserved for expansion]

23 SUBCHAPTER E. PROCEDURES REGARDING PREMIUM RATES, POLICY FORMS,
24 AND OTHER RELATED MATTERS

25 Revised Law

26 Sec. 2703.201. HEARING REQUIRED FOR FIXING PREMIUM
27 RATE. Before a premium rate may be fixed and a premium charged, the
28 department must provide reasonable notice and a hearing must be
29 afforded to title insurance companies, title insurance agents, and
30 the public. (V.T.I.C. Art. 9.07, Sec. (a) (part).)

31 Source Law

32 (a) . . . Before any premium rate provided for
33 herein shall be fixed or charged, reasonable notice
34 shall issue, and a hearing afforded to the title
35 insurance companies and title insurance agents
36 authorized or qualified under this Chapter and the
37 public. . . .

38 Revised Law

39 Sec. 2703.202. HEARING REQUIRED FOR CHANGE IN PREMIUM
40 RATE. (a) A premium rate previously fixed by the commissioner may

1 not be changed until after the commissioner holds a public hearing.

2 (b) At the request of a title insurance company or the
3 office of public insurance counsel, the commissioner shall order a
4 public hearing to consider changing a premium rate. (V.T.I.C. Art.
5 9.07, Sec. (d) (part).)

6 Source Law

7 (d) Premium rates when once fixed shall not be
8 changed until after a public hearing shall be had by
9 the commissioner. . . . The commissioner must call
10 such additional hearings to consider premium rate
11 changes at the request of a title insurance company or
12 the office of public insurance counsel.

13 Revised Law

14 Sec. 2703.203. BIENNIAL HEARING. The commissioner shall
15 hold a biennial public hearing not earlier than July 1 of each
16 even-numbered year to consider adoption of premium rates and other
17 matters relating to regulating the business of title insurance that
18 an association, title insurance company, title insurance agent, or
19 member of the public requests to be considered or that the
20 commissioner determines necessary to consider. (V.T.I.C. Art.
21 9.07, Sec. (c) (part).)

22 Source Law

23 (c) The commissioner shall hold a biennial
24 hearing not earlier than July 1 of each even-numbered
25 calendar year, to consider adoption of premium rates
26 and such other matters and subjects relative to the
27 regulation of the business of title insurance as may be
28 requested by any association, any title insurance
29 company, any title insurance agent, any member of the
30 public, or as the commissioner may determine necessary
31 to consider. . . . the public hearing

32 Revisor's Note

33 Section (c), V.T.I.C. Article 9.07, requires the
34 commissioner of insurance to hold a hearing each
35 even-numbered calendar year. The revised law omits as
36 unnecessary the reference to "calendar." An
37 even-numbered year may only be a calendar year.

38 Revised Law

39 Sec. 2703.204. ADMISSION AS PARTY TO BIENNIAL HEARING. An
40 individual or association or other entity recommending adoption of

1 a premium rate or another matter relating to regulating the
2 business of title insurance shall be admitted as a party to the
3 biennial hearing. (V.T.I.C. Art. 9.07, Sec. (c) (part).)

4 Source Law

5 (c) . . . Any person, association, or entity
6 recommending adoption of premium rates or other
7 matters and subjects shall be admitted as a party to
8 the hearing. . . .

9 Revised Law

10 Sec. 2703.205. PHASES OF BIENNIAL HEARING. (a) The
11 biennial hearing consists of:

12 (1) a rulemaking phase to consider rules, forms,
13 endorsements, and related matters that do not have rate
14 implications; and

15 (2) a ratemaking phase to consider fixing of premium
16 rates and other matters that have rate implications.

17 (b) The commissioner shall certify which matters have rate
18 implications to be considered in the ratemaking phase of the
19 hearing.

20 (c) Except as provided by Subsection (d), the commissioner
21 shall conduct both phases of the hearing.

22 (d) At the direction of the commissioner or at the written
23 request of a person seeking admission as a party to the ratemaking
24 phase of the hearing, the State Office of Administrative Hearings
25 shall conduct the ratemaking phase of the hearing in accordance
26 with Chapter 40. A request under this subsection must be made at
27 the time a person seeks to be admitted as a party to the hearing but
28 may not be made later than the 10th day after the date notice of the
29 hearing is provided under Section 2703.207.

30 (e) The ratemaking phase of the hearing shall be conducted
31 as a contested case in accordance with Chapter 2001, Government
32 Code.

33 (f) A party's presentation of relevant, admissible oral
34 testimony may not be limited.

35 (g) Each matter in each phase of the hearing shall be

1 considered by the commissioner and decisions on the matters made in
2 an open meeting. (V.T.I.C. Art. 9.07, Sec. (c) (part).)

3 Source Law

4 (c) . . . The hearing shall consist of a
5 rulemaking phase for consideration of rules, forms,
6 and endorsements, and related matters not having rate
7 implications and a ratemaking phase for consideration
8 of fixing the premium rate and other matters with rate
9 implications. The commissioner shall certify which
10 matters have rate implications to be considered in the
11 ratemaking phase of the hearing. The commissioner
12 shall conduct both phases of the hearing; provided,
13 however, that the ratemaking phase of the hearing
14 shall be conducted by the State Office of
15 Administrative Hearings in accordance with Article
16 1.33B of this code at the direction of the commissioner
17 or at the written request of any person seeking
18 admission as a party to the ratemaking phase of the
19 hearing. Such request must be made at the time a
20 person seeks to be admitted as a party to the hearing
21 but in no event more than 10 days after issuance of
22 public notice of the hearing. The ratemaking phase of
23 the hearing shall be conducted as a contested case
24 pursuant to Chapter 2001, Government Code
25 (Administrative Procedure Act). Presentation by any
26 party of relevant, admissible oral testimony shall not
27 be limited. All matters in all phases of the hearing
28 shall be considered by the commissioner and decisions
29 thereon rendered in open meeting. . . .

30 Revised Law

31 Sec. 2703.206. COMMISSIONER AUTHORITY TO HOLD HEARINGS AS
32 NECESSARY. At any time, the commissioner may order a public
33 hearing to consider adoption of premium rates and other matters
34 relating to regulating the business of title insurance as the
35 commissioner determines necessary or proper. (V.T.I.C. Art. 9.07,
36 Sec. (e) (part).)

37 Source Law

38 (e) The commissioner may, on his or her own
39 motion . . . hold at any time a public hearing to
40 consider adoption of premium rates and such other
41 matters and subjects relative to the regulation of the
42 business of title insurance as the commissioner shall
43 determine necessary or proper.

44 Revised Law

45 Sec. 2703.207. NOTICE OF CERTAIN HEARINGS. Not later than
46 the 60th day before the date of a hearing under Section 2703.202,
47 2703.203, or 2703.206, notice of the hearing and of each item to be
48 considered at the hearing shall be:

49 (1) sent directly to all title insurance companies and

1 title insurance agents; and

2 (2) provided to the public in a manner that gives fair
3 notice concerning the hearing. (V.T.I.C. Art. 9.07, Secs. (c)
4 (part), (d) (part), (e) (part).)

5 Source Law

6 (c) . . . Not less than 60 days prior to [the
7 public hearing], notice of the hearing and the items to
8 be considered shall be sent direct to all title
9 insurance companies and title insurance agents
10 qualified or authorized to do business under this
11 Chapter and to the public in such a manner as to give
12 fair publicity thereto. . . .

13 (d) . . . Not less than 60 days prior to the
14 public hearing, notice of the hearing and the items to
15 be considered shall be sent direct to all title
16 insurance companies and title insurance agents
17 qualified or authorized to do business under this
18 Chapter, and public notice shall be provided in such
19 manner as to give fair publicity thereto. . . .

20 (e) [The commissioner may, on his or her own
21 motion], following notice as required for the biennial
22 hearing [hold at any time a public hearing]

23 Revisor's Note

24 Sections (c) and (d), V.T.I.C. Article 9.07,
25 require public notice of certain hearings to be given
26 "in such [a] manner as to give fair publicity thereto."
27 The revised law substitutes "notice" for "publicity"
28 because, in context, the terms are synonymous and
29 "notice" is more commonly used.

30 Revised Law

31 Sec. 2703.208. ADDITIONS OR AMENDMENTS TO MANUAL. (a) An
32 addition or amendment to the Basic Manual of Rules, Rates, and Forms
33 for the Writing of Title Insurance in the State of Texas may be
34 proposed and adopted by reference by publishing notice of the
35 proposal or adoption by reference in the Texas Register.

36 (b) Notice under this section must include:

37 (1) a brief summary of the substance of the matter to
38 be added or amended; and

39 (2) a statement that the full text of the matter is
40 available for review in the office of the chief clerk of the
41 department. (V.T.I.C. Art. 9.07, Sec. (c) (part).)

1 Source Law

2 (c) . . . Changes to the Basic Manual of Rules,
3 Rates, and Forms for the Writing of Title Insurance in
4 the State of Texas, including additions or amendments
5 thereto, may be proposed and adopted by reference by
6 publishing a notice of such proposal or adoption by
7 reference in the Texas Register. The notice must
8 include a brief summary of the substance of the matter
9 to be added or changed and a statement that the full
10 text of the matter is available for review in the
11 office of the chief clerk of the Texas Department of
12 Insurance.

13 Revisor's Note
14 (End of Chapter)

15 Section (f), V.T.I.C. Article 9.07, allows an
16 appeal of an action of the commissioner regarding
17 premium rates or another action of the commissioner
18 "in accordance with" V.T.I.C. Article 1.04, codified
19 in 1999 as Subchapter D, Chapter 36, Insurance Code.
20 The revised law omits the provision as redundant
21 because an action of the commissioner under Article
22 9.07 is already subject to appeal in the manner
23 provided by Subchapter D, Chapter 36, and an
24 additional statement to that effect in this chapter is
25 unnecessary. The omitted law reads:

26 (f) Any title insurance company, any
27 title insurance agent, or other person or
28 association of persons interested, feeling
29 injured by any action of the commissioner
30 with regard to premium rates or other action
31 taken by the commissioner, shall have the
32 right to appeal in accordance with Article
33 1.04 of this code.

34 CHAPTER 2704. ISSUANCE OF POLICY OR CONTRACT;

35 DETERMINATION OF INSURABILITY

36 SUBCHAPTER A. GENERAL PROVISIONS

37 Sec. 2704.001. ISSUANCE OF POLICY OR CONTRACT 1675
38 Sec. 2704.002. DIRECT ISSUANCE OF POLICY OR CONTRACT 1676
39 Sec. 2704.003. COPY OF POLICY OR CONTRACT TO AGENT
40 OR DIRECT OPERATION 1677
41 Sec. 2704.004. EXCEPTIONS TO APPLICABILITY OF CHAPTER 1678

42 [Sections 2704.005-2704.050 reserved for expansion]

1 SUBCHAPTER B. ISSUANCE OF OWNER AND MORTGAGEE POLICIES

2 FOR RESIDENTIAL REAL PROPERTY

3 Sec. 2704.051. ISSUANCE OF OWNER POLICY REQUIRED
4 IN CONNECTION WITH ISSUANCE OF
5 MORTGAGEE POLICY 1678
6 Sec. 2704.052. REJECTION OF ISSUANCE OF OWNER POLICY 1679

7 [Sections 2704.053-2704.100 reserved for expansion]

8 SUBCHAPTER C. TITLE INSURANCE COVERING AREAS AND BOUNDARIES

9 Sec. 2704.101. DEFINITION 1680
10 Sec. 2704.102. RULES AUTHORIZING ACCEPTANCE OF
11 EXISTING SURVEY 1680
12 Sec. 2704.103. CERTAIN DISCRIMINATION PROHIBITED. 1681
13 Sec. 2704.104. INDEMNITY PROHIBITED 1681

14 CHAPTER 2704. ISSUANCE OF POLICY OR CONTRACT;

15 DETERMINATION OF INSURABILITY

16 SUBCHAPTER A. GENERAL PROVISIONS

17 Revised Law

18 Sec. 2704.001. ISSUANCE OF POLICY OR CONTRACT. A title
19 insurance policy or contract may not be written unless:

20 (1) Sections 2502.053, 2502.054, and 2502.055 have
21 been complied with;

22 (2) the policy or contract is based on an examination
23 of title made from title evidence prepared from an abstract plant
24 owned, or leased and operated by a title insurance agent or direct
25 operation for the county in which the real property is located,
26 except as provided by Section 2704.002;

27 (3) insurability of title has been determined in
28 accordance with sound title underwriting practices; and

29 (4) evidence thereof is preserved and retained in the
30 files of the title insurance company, title insurance agent, or
31 direct operation for a period of not less than 15 years after the
32 date of issuance of the policy or contract. (V.T.I.C. Art. 9.34
33 (part).)

1 Source Law

2 Art. 9.34. No policy or contract of title
3 insurance shall be written unless (1) there has been
4 compliance with the provisions of Article 9.30(B), (2)
5 said policy or contract of title insurance is based on
6 an examination of title made from title evidence
7 prepared from an abstract plant owned, or leased and
8 operated by a licensed Texas title insurance agent or
9 direct operation for the county in which the real
10 property is located, (3) there has been made a
11 determination of insurability of title in accordance
12 with sound title underwriting practices, and (4)
13 evidence thereof shall be preserved and retained in
14 the files of the title insurance company, direct
15 operation, or title insurance agent for a period of not
16 less than fifteen (15) years after the policy or
17 contract of title insurance has been issued. . . .

18 Revisor's Note

19 V.T.I.C. Article 9.34 refers to a "licensed Texas
20 title insurance agent or direct operation."
21 Throughout this chapter, the revised law omits
22 "licensed" as unnecessary in this context because
23 under V.T.I.C. Articles 9.35 and 9.36A, which are
24 revised in relevant part as Sections 2651.001 and
25 2651.051 of this code, a person may not act as an agent
26 or direct operation in this state unless the person
27 holds a license.

28 Revised Law

29 Sec. 2704.002. DIRECT ISSUANCE OF POLICY OR CONTRACT. A
30 title insurance company may directly issue a title insurance policy
31 or contract based on the best title evidence available if:

32 (1) a title insurance agent or direct operation does
33 not exist for the county in which the real property is located; or

34 (2) each title insurance agent and direct operation
35 for that county refuses to provide title evidence:

36 (A) in a reasonable period as determined by the
37 department; and

38 (B) in compliance with Section 2502.053(1).
39 (V.T.I.C. Art. 9.34 (part).)

40 Source Law

41 Art. 9.34. . . . If no licensed title
42 insurance agent or direct operation exists for the
43 county in which the real property is located, a title

1 insurance company may directly issue its policy of
2 title insurance based on the best title evidence
3 available. If all licensed title insurance agents and
4 direct operations for the county refuse to provide the
5 title evidence within such reasonable time as
6 determined by the Board, and in compliance with the
7 provisions of Article 9.30(B)(2), the title insurance
8 company may directly issue its policy if the title
9 insurance company obtains the best title evidence
10 available. . . .

11 Revisor's Note

12 (1) V.T.I.C. Article 9.34 generally refers to a
13 title insurance "policy or contract." Some sentences
14 in the article, however, refer only to a "policy." For
15 consistency throughout this subchapter, the revised
16 law refers to a "policy or contract."

17 (2) V.T.I.C. Article 9.34, in the second
18 sentence, refers to direct issuance of a title
19 insurance policy "based on the best title evidence
20 available." The third sentence refers to direct
21 issuance if the title insurance company "obtains the
22 best title evidence available." For consistency, and
23 based on the context, the revised law refers to direct
24 issuance "based on the best title evidence available."

25 (3) V.T.I.C. Article 9.34 refers to the "Board,"
26 meaning the State Board of Insurance. Chapter 685,
27 Acts of the 73rd Legislature, Regular Session, 1993,
28 abolished the board and transferred its functions to
29 the commissioner of insurance and the Texas Department
30 of Insurance. Throughout this chapter, references to
31 the board have been changed appropriately.

32 Revised Law

33 Sec. 2704.003. COPY OF POLICY OR CONTRACT TO AGENT OR DIRECT
34 OPERATION. In a reasonable period as determined by the department,
35 a copy of each title insurance policy or contract issued in a real
36 property transaction shall be provided to each title insurance
37 agent or direct operation providing the title evidence on which the
38 policy or contract is issued. (V.T.I.C. Art. 9.34 (part).)

1 Source Law

2 Art. 9.34. . . . The licensed Texas title
3 insurance agent or direct operation which provided the
4 title evidence on which the policies or contracts of
5 title insurance are issued shall be provided with
6 legible complete copies of all policies or contracts
7 of title insurance actually issued in the transactions
8 within a reasonable period of time as determined by the
9 Board. . . .

10 Revisor's Note

11 V.T.I.C. Article 9.34 refers to "legible
12 complete" copies of title insurance policies or
13 contracts. The revised law omits the quoted language
14 as unnecessary because its meaning is included in the
15 meaning of a "copy." The absence of the terms does not
16 imply that one can provide illegible or incomplete
17 copies and still comply with the law.

18 Revised Law

19 Sec. 2704.004. EXCEPTIONS TO APPLICABILITY OF CHAPTER.
20 This chapter does not apply to a company that:

21 (1) does not assume primary liability in a reinsurance
22 contract; or

23 (2) acts as coinsurer, if at least one of the other
24 coinsurers has complied with this chapter. (V.T.I.C. Art. 9.34
25 (part).)

26 Source Law

27 Art. 9.34. . . . This Article shall not apply
28 to (a) a company assuming no primary liability in a
29 contract of reinsurance, or (b) a company acting as a
30 co-insurer if one of the other co-insuring companies
31 has complied with this Article.

32 [Sections 2704.005-2704.050 reserved for expansion]

33 SUBCHAPTER B. ISSUANCE OF OWNER AND MORTGAGEE POLICIES FOR
34 RESIDENTIAL REAL PROPERTY

35 Revised Law

36 Sec. 2704.051. ISSUANCE OF OWNER POLICY REQUIRED IN
37 CONNECTION WITH ISSUANCE OF MORTGAGEE POLICY. (a) In this
38 section, "mortgagee title insurance policy" means a mortgagee
39 policy of title insurance or another agreement or the equivalent
40 that constitutes the business of title insurance.

1 (b) Except as provided by Section 2704.052, a title
2 insurance company or title insurance agent that issues a mortgagee
3 title insurance policy in connection with a lien on improved
4 residential real property in this state that is sold shall also
5 issue an owner title insurance policy to the owner of the property.

6 (c) The title insurance company or title insurance agent
7 issuing the owner title insurance policy shall charge the required
8 premium promulgated by the commissioner. (V.T.I.C. Art. 9.55
9 (part).)

10 Source Law

11 Art. 9.55. After January 1, 1976, whenever any
12 improved residential real property situated in the
13 State of Texas shall be sold and a mortgagee policy of
14 title insurance or other form of agreement or the
15 equivalent thereof that constitutes the business of
16 title insurance is issued in connection with a lien
17 thereon, the title insurance company or title
18 insurance agent so issuing such mortgagee policy of
19 title insurance form or agreement or the equivalent
20 thereof shall also issue an owner policy of title
21 insurance to the owner of such property and the
22 required premium as promulgated by the commissioner
23 shall be charged. . . .

24 Revisor's Note

25 V.T.I.C. Article 9.55 requires compliance with
26 the article after January 1, 1976. The revised law
27 omits as unnecessary the reference to that date.
28 Because that date has already passed, unless the
29 specified exception applies, compliance with the
30 article is required in all cases described by the
31 article regardless of the date.

32 Revised Law

33 Sec. 2704.052. REJECTION OF ISSUANCE OF OWNER POLICY. At
34 or before closing and settlement, the person acquiring title may
35 reject the issuance of the owner title insurance policy required
36 under Section 2704.051 by executing a written and acknowledged
37 rejection in the form prescribed, after notice and hearing, by the
38 commissioner. (V.T.I.C. Art. 9.55 (part).)

39 Source Law

40 Art. 9.55. . . . The provisions of this

1 article may, however, be rejected, provided that the
2 person acquiring title shall, at or prior to closing
3 and settlement, execute a written and acknowledged
4 rejection wherein the purchaser rejects issuance of
5 such owner title policy. The form of such rejection
6 shall be prescribed, after notice and hearing, by the
7 commissioner.

8 [Sections 2704.053-2704.100 reserved for expansion]

9 SUBCHAPTER C. TITLE INSURANCE COVERING AREAS AND BOUNDARIES

10 Revised Law

11 Sec. 2704.101. DEFINITION. In this subchapter, "area and
12 boundary coverage" means title insurance coverage relating to
13 discrepancies, conflicts, or shortages in area or boundary lines,
14 or any encroachments or protrusions, or any overlapping of
15 improvements. (V.T.I.C. Art. 9.07C, Sec. (a).)

16 Source Law

17 Art. 9.07C. (a) In this article, "area and
18 boundary coverage" means title insurance coverage
19 relating to discrepancies, conflicts, or shortages in
20 area or boundary lines, or any encroachments or
21 protrusions, or any overlapping of improvements.

22 Revised Law

23 Sec. 2704.102. RULES AUTHORIZING ACCEPTANCE OF EXISTING
24 SURVEY. (a) The commissioner by rule may authorize a title
25 insurance company providing area and boundary coverage to accept an
26 existing real property survey as provided by this section.

27 (b) A title insurance company may accept an existing real
28 property survey rather than requiring a new survey if,
29 notwithstanding the age of the survey or the identity of the person
30 for whom the survey was prepared, the company is willing to accept:

31 (1) evidence of the existing survey; and

32 (2) an affidavit prescribed by the commissioner that
33 verifies the existing survey. (V.T.I.C. Art. 9.07C, Sec. (b).)

34 Source Law

35 (b) The commissioner may adopt rules allowing a
36 title insurance company to accept an existing real
37 property survey and not require a new survey when
38 providing area and boundary coverage if the title
39 insurance company is willing to accept evidence of an
40 existing real property survey, and an affidavit
41 verifying the existing survey, as prescribed by the
42 commissioner, notwithstanding the age of the survey or
43 the identity of the person for whom the survey was
44 prepared.

1 Revised Law

2 Sec. 2704.103. CERTAIN DISCRIMINATION PROHIBITED. A title
3 insurance company may not discriminate in providing area and
4 boundary coverage in connection with residential real property
5 solely because:

6 (1) the real property is platted or unplatted; or

7 (2) a municipality did not accept a subdivision plat
8 relating to the real property before September 1, 1975. (V.T.I.C.
9 Art. 9.07C, Sec. (c).)

10 Source Law

11 (c) A title insurance company may not
12 discriminate in providing area and boundary coverage
13 in connection with residential real property solely
14 because:

15 (1) the real property is platted or
16 unplatted; or

17 (2) a municipality did not accept a
18 subdivision plat in relation to the real property
19 before September 1, 1975.

20 Revised Law

21 Sec. 2704.104. INDEMNITY PROHIBITED. A title insurance
22 company may not require an indemnity from a seller, buyer,
23 borrower, or lender to provide area and boundary coverage.
24 (V.T.I.C. Art. 9.07C, Sec. (d).)

25 Source Law

26 (d) A title insurance company may not require an
27 indemnity from a seller, buyer, borrower, or lender to
28 provide area and boundary coverage.

29 TITLE 13. REGULATION OF PROFESSIONALS

30 SUBTITLE A. GENERAL PROVISIONS

31 CHAPTER 4001. AGENT LICENSING IN GENERAL

32 CHAPTER 4002. EXAMINATION OF LICENSE APPLICANTS

33 CHAPTER 4003. LICENSE EXPIRATION AND RENEWAL

34 CHAPTER 4004. CONTINUING EDUCATION

35 CHAPTER 4005. CONDUCT, DISCIPLINARY ACTIONS, AND SANCTIONS

36 CHAPTER 4006. DISABILITY PROBATION OF AGENTS

37 [Chapters 4007-4050 reserved for expansion]

38 SUBTITLE B. AGENTS

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5	CHAPTER 4056.	NONRESIDENT AGENTS	
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8	CHAPTER 4101.	INSURANCE ADJUSTERS	
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10		SUBTITLE D. OTHER PROFESSIONALS	
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2 SUBCHAPTER C. LICENSE REQUIREMENTS

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8 CORPORATE AGENCY 1736

9 CHAPTER 4001. AGENT LICENSING IN GENERAL

10 SUBCHAPTER A. GENERAL PROVISIONS

11 Revised Law

12 Sec. 4001.001. PURPOSE. It is the intent of the
13 legislature to:

14 (1) simplify and reform the regulation of agents and
15 other persons regulated under this title in this state by
16 consolidating the kinds of licenses issued to those persons under
17 this title; and

18 (2) promote uniformity in the licensing, examination,
19 continuing education, and disciplinary requirements for those
20 persons in this state and with other states. (V.T.I.C. Art. 21.01,
21 Sec. 1.)

22 Source Law

23 Art. 21.01
24 Sec. 1. It is the intent of the legislature to:
25 (1) simplify and reform the regulation of
26 insurance agents in this state by consolidating the
27 types of licenses issued to insurance agents under
28 this subchapter; and
29 (2) promote uniformity in the licensing,
30 examination, continuing education, and disciplinary
31 requirements for agents in this state and with other
32 states.

33 Revisor's Note

34 Section 1, V.T.I.C. Article 21.01, refers to "the
35 regulation of insurance agents," "licenses issued to
36 insurance agents," and licensing, examination,
37 continuing education, and disciplinary requirements
38 "for agents." The revised law adds a reference to

1 "other persons regulated under this title" for clarity
2 and consistency within this title. In addition to
3 agents, persons such as adjusters, third-party
4 administrators, and life and health insurance
5 counselors are regulated under Subchapter A, V.T.I.C.
6 Chapter 21, revised as this title.

7 Revised Law

8 Sec. 4001.002. APPLICABILITY. (a) Except as otherwise
9 provided by this code, this title applies to each person licensed
10 under:

- 11 (1) Subchapter H, Chapter 885;
- 12 (2) Subchapter F, Chapter 911;
- 13 (3) Section 912.251;
- 14 (4) Subchapter E, Chapter 981;
- 15 (5) Subchapter D, Chapter 1152;
- 16 (6) Subchapter C or D of this chapter;
- 17 (7) Subtitle B, C, or D of this title;
- 18 (8) Article 23.23A; or
- 19 (9) Subsection (c), Article 5.13-1.

20 (b) This title does not apply to:

21 (1) a resident of this state who arbitrates in the
22 adjustment of losses between an insurer and an insured, a marine
23 adjuster who adjusts particular or general average losses of
24 vessels or cargoes if the adjuster paid an occupation tax of \$200
25 for the year in which the adjustment is made, or a practicing
26 attorney at law in this state, acting in the regular transaction of
27 the person's business as an attorney at law, who is not a local
28 agent and is not acting as an adjuster for an insurer;

29 (2) a full-time home office salaried employee of an
30 insurer authorized to engage in the business of insurance in this
31 state, other than an employee who solicits or receives an
32 application for the sale of insurance through an oral, written, or
33 electronic communication in accordance with Subchapter G, Chapter
34 4051;

1 (3) an attorney in fact or the traveling salaried
2 representative of a reciprocal or interinsurance exchange admitted
3 to engage in the business of insurance in this state as to business
4 transacted through the attorney in fact or salaried representative;

5 (4) the attorney in fact for a Lloyd's plan;

6 (5) the group motor vehicle insurance business or the
7 group motor vehicle department of a company engaged in that
8 business; or

9 (6) a salaried employee who is not involved in
10 soliciting or negotiating insurance in the office of an agent and
11 who devotes the employee's full time to clerical and administrative
12 services, including the incidental taking of information from
13 customers and receipt of premiums in the office of an agent, if:

14 (A) the employee does not receive any
15 commissions; and

16 (B) the employee's compensation is not varied by
17 the volume of premiums taken and received. (V.T.I.C. Art. 21.01,
18 Sec. 3; Art. 21.02, Sec. (a) (part); Art. 21.07, Sec. 1(b).)

19 Source Law

20 [Art. 21.01]

21 Sec. 3. Except as otherwise provided by this
22 code, this subchapter applies to each person licensed
23 in accordance with:

24 (1) Section 4, Article 1.14-2, of this
25 code;

26 (2) Section 7, Article 3.75, of this code;

27 (3) Subsection (c), Article 5.13-1, of
28 this code;

29 (4) Article 10.37-3 of this code;

30 (5) Article 16.24A of this code;

31 (6) Section 9, Article 17.25, of this
32 code;

33 (7) Article 21.07 of this code;

34 (8) Article 21.07-1 of this code;

35 (9) Chapter 29, Acts of the 54th
36 Legislature, Regular Session, 1955 (Article 21.07-2,
37 Vernon's Texas Insurance Code);

38 (10) the Managing General Agents'
39 Licensing Act (Article 21.07-3, Vernon's Texas
40 Insurance Code);

41 (11) Chapter 407, Acts of the 63rd
42 Legislature, Regular Session, 1973 (Article 21.07-4,
43 Vernon's Texas Insurance Code);

44 (12) Article 21.07-6 of this code;

45 (13) Article 21.07-7 of this code;

46 (14) Article 21.09 of this code;

47 (15) Article 21.11 of this code;

48 (16) Article 21.14 of this code;

- 1 (17) Article 21.14-1 of this code;
- 2 (18) Article 21.14-2 of this code; or
- 3 (19) Article 23.23A of this code.

4 [Art. 21.02]

5 (a) . . . The provisions of this subchapter
6 shall not apply to citizens of this State who arbitrate
7 in the adjustment of losses between the insurers and
8 insured, nor to the adjustment of particular or
9 general average losses of vessels or cargoes by marine
10 adjusters who had paid an occupation tax of \$200 for
11 the year in which the adjustment is made, nor to
12 practicing attorneys at law in the State of Texas,
13 acting in the regular transaction of their business as
14 such attorneys at law, and who are not local agents,
15 nor acting as adjusters for any insurance
16 company. . . .

17 [Art. 21.07]

18 [Sec. 1]

19 (b) This subchapter does not apply to:

20 (1) an actual full-time home office
21 salaried employee of an insurance carrier licensed to
22 do business in this state, other than an employee who
23 solicits or receives an application for the sale of
24 insurance through an oral, written, or electronic
25 communication in accordance with Article 21.14 of this
26 code;

27 (2) an actual attorney in fact or the
28 actual traveling salaried representative of a
29 reciprocal exchange or interinsurance exchange
30 admitted to do business in this state as to business
31 transacted through the attorney in fact or salaried
32 representative;

33 (3) the actual attorney in fact for a
34 Lloyd's plan insurer;

35 (4) the group motor vehicle insurance
36 business or the group motor vehicle department of
37 companies engaged in that business; or

38 (5) a salaried employee who is not
39 involved in the solicitation or negotiation of
40 insurance in the office of a licensed agent who devotes
41 the employee's full time to clerical and
42 administrative services, including the incidental
43 taking of information from customers and receipt of
44 premiums in the office of a licensed agent, if the
45 employee does not receive any commissions and the
46 employee's compensation is not varied by the volume of
47 premiums taken and received.

48 Revisor's Note

49 (1) Section (a), V.T.I.C. Article 21.02, refers
50 to "citizens of this State." The revised law
51 substitutes "resident" for "citizens" because, in
52 context, "citizens" and "resident" are synonymous, and
53 "resident" is more commonly used.

54 (2) Section 1(b), V.T.I.C. Article 21.07,
55 refers to an "actual full-time home office salaried
56 employee," an "actual attorney in fact," and an

1 "actual traveling salaried representative." The
2 revised law omits "actual" as unnecessary. An
3 individual is not a full-time home office salaried
4 employee, attorney in fact, or traveling salaried
5 representative if the individual is not an actual
6 full-time home office salaried employee, attorney in
7 fact, or traveling salaried representative,
8 respectively.

9 (3) Section 1(b)(1), V.T.I.C. Article 21.07,
10 refers to an insurer "licensed to do business in this
11 state," meaning an insurer that holds a certificate of
12 authority and thus is authorized to engage in the
13 business of insurance in this state. For consistency
14 with the terminology used in this code, the revised law
15 substitutes "authorized to engage in" for "licensed to
16 do" throughout this chapter.

17 (4) Section 1(b)(5), V.T.I.C. Article 21.07,
18 refers to a "licensed agent." Throughout this
19 chapter, the revised law omits "licensed" as
20 unnecessary in this context because under Section 2,
21 V.T.I.C. Article 21.01, and Section 1(a), V.T.I.C.
22 Article 21.07, revised in pertinent part in Section
23 4001.101, a person may not act as an agent unless the
24 person holds a license.

25 Revised Law

26 Sec. 4001.003. DEFINITIONS. Unless the context clearly
27 indicates otherwise, in this title:

28 (1) "Agent" means a person who is an authorized agent
29 of an insurer or health maintenance organization, a subagent, and
30 any other person who performs the acts of an agent, whether through
31 an oral, written, electronic, or other form of communication, by
32 soliciting, negotiating, procuring, or collecting a premium on an
33 insurance or annuity contract, or who represents or purports to
34 represent a health maintenance organization, including a health

1 maintenance organization offering only a single health care service
2 plan, in soliciting, negotiating, procuring, or effectuating
3 membership in the health maintenance organization. The term does
4 not include:

5 (A) a regular salaried officer or employee of an
6 insurer, health maintenance organization, or agent who:

7 (i) devotes substantially all of the
8 officer's or employee's time to activities other than the
9 solicitation of applications for insurance, annuity contracts, or
10 memberships;

11 (ii) does not receive a commission or other
12 compensation directly dependent on the business obtained; and

13 (iii) does not solicit or accept from the
14 public applications for insurance, annuity contracts, or
15 memberships;

16 (B) an employer or an employer's officer or
17 employee or a trustee of an employee benefit plan, to the extent
18 that the employer, officer, employee, or trustee is engaged in the
19 administration or operation of an employee benefits program
20 involving the use of insurance or annuities issued by an insurer or
21 memberships issued by a health maintenance organization, if the
22 employer, officer, employee, or trustee is not directly or
23 indirectly compensated by the insurer or health maintenance
24 organization issuing the insurance or annuity contracts or
25 memberships;

26 (C) except as otherwise provided by this code, a
27 depository institution, or an officer or employee of a depository
28 institution, to the extent that the depository institution or
29 officer or employee collects and remits premiums or charges by
30 charging those premiums or charges against accounts of depositors
31 on the orders of those depositors; or

32 (D) a person or the employee of a person who has
33 contracted to provide administrative, management, or health care
34 services to a health maintenance organization and who is

1 compensated for those services by the payment of an amount computed
2 as a percentage of the revenues, net income, or profit of the health
3 maintenance organization, if that method of compensation is the
4 sole basis for subjecting that person or the employee of the person
5 to this title.

6 (2) "Control" means the power to direct or cause the
7 direction of the management and policies of a license holder,
8 whether directly or indirectly. For the purposes of this title, a
9 person is considered to control:

10 (A) a corporate license holder if the person,
11 individually or acting with others, directly or indirectly, holds
12 with the power to vote, owns, or controls, or holds proxies
13 representing, at least 10 percent of the voting stock or voting
14 rights of the corporate license holder; or

15 (B) a partnership if the person through a right
16 to vote or through any other right or power exercises rights in the
17 management, direction, or conduct of the business of the
18 partnership.

19 (3) "Corporation" means a legal entity that is
20 organized under the business corporation laws or limited liability
21 company laws of this state or another state and that has as one of
22 its purposes the authority to act as an agent.

23 (4) "Depository institution" means:

24 (A) a bank or savings association as defined by
25 12 U.S.C. Section 1813, as amended;

26 (B) a foreign bank that maintains a branch,
27 agency, or commercial lending company in the United States;

28 (C) a federal or state credit union as defined by
29 12 U.S.C. Section 1752, as amended;

30 (D) a bank branch; or

31 (E) a bank subsidiary, as defined by state or
32 federal law.

33 (5) "Individual" means a natural person. The term
34 includes a resident or a nonresident of this state.

1 (6) "Insurer" means an insurance company or insurance
2 carrier regulated by the department. The term includes:

3 (A) a stock life, health, or accident insurance
4 company;

5 (B) a mutual life, health, or accident insurance
6 company;

7 (C) a stock fire or casualty insurance company;

8 (D) a mutual fire or casualty insurance company;

9 (E) a Mexican casualty insurance company;

10 (F) a Lloyd's plan;

11 (G) a reciprocal or interinsurance exchange;

12 (H) a fraternal benefit society;

13 (I) a stipulated premium company;

14 (J) a nonprofit or for-profit legal services
15 corporation;

16 (K) a statewide mutual assessment company;

17 (L) a local mutual aid association;

18 (M) a local mutual burial association;

19 (N) an association exempt under Section 887.102;

20 (O) a nonprofit hospital, medical, or dental
21 service corporation, including a company subject to Chapter 842;

22 (P) a health maintenance organization;

23 (Q) a county mutual insurance company; and

24 (R) a farm mutual insurance company.

25 (7) "Partnership" means an association of two or more
26 persons organized under the partnership laws or limited liability
27 partnership laws of this state or another state. The term includes
28 a general partnership, limited partnership, limited liability
29 partnership, and limited liability limited partnership.

30 (8) "Person" means an individual, partnership,
31 corporation, or depository institution.

32 (9) "Subagent" means a person engaging in activities
33 described under Subdivision (1) who acts for or on behalf of an
34 agent, whether through an oral, written, electronic, or other form

1 of communication, by soliciting, negotiating, or procuring an
2 insurance or annuity contract or health maintenance organization
3 membership, or collecting premiums or charges on an insurance or
4 annuity contract or health maintenance organization membership,
5 without regard to whether the subagent is designated by the agent as
6 a subagent or by any other term. A subagent is an agent for all
7 purposes of this title, and a reference to an agent in this title,
8 Chapter 21, or a provision listed in Section 4001.009 includes a
9 subagent without regard to whether a subagent is specifically
10 mentioned. (V.T.I.C. Art. 21.07, Secs. 1A(1), (2), (3) (part),
11 (4), (5), (6), (7), (8), (9).)

12 Source Law

13 Sec. 1A. Unless the context clearly indicates
14 otherwise, in this subchapter:

15 (1) "Agent" means a person who is an
16 authorized agent of an insurance company or health
17 maintenance organization, any person who is a subagent
18 of an agent, and any other person who performs the acts
19 of an agent, whether through an oral, written, or
20 electronic communication or otherwise, in the
21 solicitation of, negotiation for, procurement of, or
22 collection of premiums on an insurance or annuity
23 contract, or who represents or purports to represent a
24 health maintenance organization, including a health
25 maintenance organization offering only a single health
26 care service plan, in the solicitation of, negotiation
27 for, procurement of, or effectuation of membership in
28 the health maintenance organization. The term does
29 not include:

30 (A) a regular salaried officer or
31 employee of an insurance company, health maintenance
32 organization, or insurance agent who:

33 (i) devotes substantially all
34 of the officer's or employee's time to activities other
35 than the solicitation of applications for insurance,
36 annuity contracts, or memberships;

37 (ii) does not receive a
38 commission or other compensation directly dependent on
39 the business obtained; and

40 (iii) does not solicit or
41 accept from the public applications for insurance,
42 annuity contracts, or memberships;

43 (B) an employer or an employer's
44 officers or employees or the trustees of an employee
45 benefit plan, to the extent that those employers,
46 officers, employees, or trustees are engaged in the
47 administration or operation of any program of employee
48 benefits involving the use of insurance or annuities
49 issued by an insurance company or memberships issued
50 by a health maintenance organization, if those
51 employers, officers, employees, or trustees are not
52 compensated, directly or indirectly, by the insurance
53 company or health maintenance organization issuing the
54 insurance or annuity contracts or memberships;

55 (C) except as otherwise provided by

1 this code, a depository institution, or the officers
2 and employees of a depository institution, to the
3 extent that the depository institution or officers and
4 employees collect and remit premiums or charges by
5 charging those premiums or charges against accounts of
6 depositors on the orders of those depositors; or

7 (D) a person or the employee of a
8 person who has contracted to provide administrative,
9 management, or health care services to a health
10 maintenance organization and who is compensated for
11 those services by the payment of an amount computed as
12 a percentage of the revenues, net income, or profit of
13 the health maintenance organization, if that method of
14 compensation is the sole basis for subjecting that
15 person or the employee of the person to this article.

16 (2) "Control" means the power to direct or
17 cause the direction of the management and policies of a
18 license holder, whether directly or indirectly. For
19 the purposes of this subchapter, a person is
20 considered to control:

21 (A) a corporate license holder if the
22 person, individually or acting with others, directly
23 or indirectly, holds with the power to vote, owns, or
24 controls, or holds proxies representing, at least 10
25 percent of the voting stock or voting rights of the
26 corporate license holder; or

27 (B) a partnership if the person
28 through a right to vote or through any other right or
29 power exercises rights in the management, direction,
30 or conduct of the business of the partnership.

31 (3) "Corporation" means a legal entity
32 that is organized under the business corporations laws
33 or limited liability company laws of this state,
34 another state, or a territory of the United States and
35 that has as one of its purposes the authority to act as
36 an insurance agent. . . .

37 (4) "Depository institution" means:

38 (A) a bank or savings association as
39 defined by 12 U.S.C. Section 1813, as amended;

40 (B) a foreign bank that maintains a
41 branch, agency, or commercial lending company in the
42 United States;

43 (C) a federal or state credit union
44 as defined by 12 U.S.C. Section 1752, as amended;

45 (D) a bank branch; or

46 (E) a bank subsidiary, as defined by
47 state or federal law.

48 (5) "Individual" means a natural person.
49 The term includes a resident or a nonresident of this
50 state.

51 (6) "Insurance company," "insurance
52 carrier," or "insurer" means an insurance company
53 regulated by the department. The term includes:

54 (A) any domestic or foreign, stock
55 and mutual, life, health, or accident insurance
56 company;

57 (B) any domestic or foreign, stock
58 and mutual, fire and casualty insurance company;

59 (C) a Mexican casualty company;

60 (D) a domestic or foreign Lloyd's
61 plan insurer;

62 (E) a domestic or foreign reciprocal
63 or interinsurance exchange;

64 (F) a domestic or foreign fraternal
65 benefit society;

66 (G) a stipulated premium insurance
67 company;

68 (H) a nonprofit or for-profit legal

1 service corporation;
2 (I) a statewide mutual assessment
3 company;
4 (J) a local mutual aid association;
5 (K) a local mutual burial
6 association;
7 (L) an exempt association under
8 Article 14.17 of this code;
9 (M) a nonprofit hospital, medical, or
10 dental service corporation, including a company
11 subject to Chapter 20 of this code;
12 (N) a health maintenance
13 organization;
14 (O) a county mutual insurance
15 company; or
16 (P) a farm mutual insurance company.

17 (7) "Partnership" means an association of
18 two or more persons organized under the partnership
19 laws or limited liability partnership laws of this
20 state, another state, or a territory of the United
21 States. The term includes a general partnership,
22 limited partnership, limited liability partnership,
23 and limited liability limited partnership.

24 (8) "Person" means an individual,
25 partnership, corporation, or depository institution.

26 (9) "Subagent" means any person engaging
27 in activities described under Subdivision (1) of this
28 section who acts for or on behalf of an agent, whether
29 through an oral, written, or electronic communication
30 or otherwise, in the solicitation of, negotiation for,
31 or procurement of an insurance or annuity contract or
32 health maintenance organization membership, or the
33 collection of premiums or charges on an insurance or
34 annuity contract or health maintenance organization
35 membership, whether or not the subagent is designated
36 by the agent as a subagent or by any other title. A
37 subagent is an agent, for all purposes of this
38 subchapter, and wherever the term "agent" is used in
39 this chapter, it includes subagents whether or not a
40 subagent is specifically mentioned.

41 Revisor's Note

42 (1) Section 1A(1), V.T.I.C. Article 21.07,
43 refers to a subagent "of an agent." The revised law
44 omits the quoted language as unnecessary because
45 Section 1A(9), V.T.I.C. Article 21.07, revised in this
46 section, defines "subagent" as a person engaging in
47 certain activities "for or on behalf of an agent."

48 (2) Sections 1A(3) and (7), V.T.I.C. Article
49 21.07, refer to an entity organized under the laws of
50 "this state, another state, or a territory of the
51 United States." Throughout this chapter, the revised
52 law omits references to "territory" in this context as
53 unnecessary because Section 311.005, Government Code
54 (Code Construction Act), which applies to the revised

1 law, provides that "state," when referring to a part of
2 the United States, includes any state or territory of
3 the United States.

4 (3) Section 1A(6), V.T.I.C. Article 21.07,
5 provides that "insurer" means an insurer regulated by
6 the department, including certain "domestic or
7 foreign" insurers. The revised law omits the
8 reference to "domestic or foreign" as unnecessary.
9 The authority of the department to regulate domestic
10 and foreign insurers is specified in other provisions
11 of the code and, because the revised law applies to all
12 insurers regulated by the department, it is not
13 necessary to distinguish between domestic and foreign
14 insurers in this section.

15 (4) Section 1A(6), V.T.I.C. Article 21.07,
16 provides that, "[u]nless the context clearly indicates
17 otherwise," in Subchapter A, V.T.I.C. Chapter 21,
18 revised in this code as this title, "insurance
19 company," "insurance carrier," and "insurer" include a
20 "health maintenance organization." A health
21 maintenance organization is not a traditional insurer,
22 and other provisions of this code commonly refer to an
23 "insurer or health maintenance organization" rather
24 than including health maintenance organization in the
25 definition of "insurer." However, that approach is
26 especially difficult in this circumstance because a
27 reference to an "insurer" in Subchapter A, Chapter 21,
28 may or may not include a health maintenance
29 organization, depending on the context. Omitting
30 health maintenance organization from the definition of
31 "insurer" in the revised law, in a manner consistent
32 with other provisions of this code, would require
33 specific determinations of whether to add references
34 to a health maintenance organization to each provision

1 of this title that applies to an "insurer." Because in
2 some instances it is unclear from the context whether a
3 provision that applies to an "insurer" is intended to
4 apply to a health maintenance organization, the
5 revised law preserves the original structure of
6 Section 1A(6) by including a health maintenance
7 organization in the definition of "insurer."

8 Revised Law

9 Sec. 4001.004. LIMITED LIABILITY COMPANIES. The licensing
10 and regulation of a limited liability company are subject to each
11 provision of this title that applies to a corporation licensed
12 under this title. (V.T.I.C. Art. 21.07, Sec. 1A(3) (part).)

13 Source Law

14 (3) The licensing and regulation of
15 a limited liability company is subject to all
16 provisions of this subchapter that apply to a
17 corporation licensed under this subchapter.

18 Revised Law

19 Sec. 4001.005. RULES. The commissioner may adopt rules
20 necessary to implement this title and to meet the minimum
21 requirements of federal law, including regulations. (V.T.I.C.
22 Art. 21.01, Sec. 4.)

23 Source Law

24 Sec. 4. The commissioner may adopt rules as
25 necessary to implement this subchapter and to meet the
26 minimum requirements of federal law and regulations.

27 Revised Law

28 Sec. 4001.006. FEES. (a) The department shall collect
29 from each agent of an insurer writing insurance in this state under
30 this code:

31 (1) a nonrefundable license fee; and

32 (2) a nonrefundable appointment fee for each
33 appointment of the agent by an insurer.

34 (b) The department shall deposit the fees described by
35 Subsection (a), together with other license fees, examination fees,
36 and license renewal fees, to the credit of the Texas Department of

1 Insurance operating account.

2 (c) The department shall set the fees in amounts reasonable
3 and necessary to implement this title and may use any portion of
4 those fees to enforce this title. (V.T.I.C. Art. 21.07, Secs.
5 6C(a), (b) (part), (c).)

6 Source Law

7 Sec. 6C. (a) The department shall collect from
8 each agent of an insurance carrier writing insurance
9 in this state under this code a nonrefundable license
10 fee and a nonrefundable appointment fee for each
11 appointment by an insurance carrier. These fees,
12 together with examination fees, license fees, and
13 license renewal fees, shall be deposited to the credit
14 of the Texas Department of Insurance operating fund.

15 (b) The department may use any portion of the
16 fees collected to enforce this subchapter,

17 (c) The department shall set the fees in amounts
18 reasonable and necessary to implement this subchapter.

19 Revisor's Note

20 Section 6C(a), V.T.I.C. Article 21.07, requires
21 certain fees to be deposited to the credit of the Texas
22 Department of Insurance operating fund. Under the
23 authority of Chapter 4, Acts of the 72nd Legislature,
24 1st Called Session, 1991, the Texas Department of
25 Insurance operating fund was converted to an account
26 in the general revenue fund. The revised law is
27 drafted accordingly.

28 Revised Law

29 Sec. 4001.007. INVESTIGATION OF ALLEGED VIOLATIONS. (a)
30 The department may:

31 (1) employ persons as the department considers
32 necessary to investigate and make reports regarding alleged
33 violations of this code and misconduct on the part of agents; and

34 (2) pay the salaries and expenses of those persons and
35 office employees and other expenses necessary to enforce this title
36 from the fees described by Section 4001.006.

37 (b) A person employed by the department under this section
38 may:

39 (1) administer the oath to, and examine under oath,

1 any person considered necessary in gathering information and
2 evidence; and

3 (2) have that information and evidence reduced to
4 writing if considered necessary.

5 (c) All expenses related to the activities described by
6 Subsection (b) shall be paid from the fees described by Section
7 4001.006. (V.T.I.C. Art. 21.07, Sec. 6C(b) (part).)

8 Source Law

9 (b) [The department] . . . may employ persons as
10 it considers necessary to investigate and make reports
11 regarding alleged violations of this code and
12 misconduct on the part of agents, and may pay the
13 salaries and expenses of those persons and office
14 employees and other expenses necessary to enforce this
15 subchapter from the fees collected. A person employed
16 by the department under this section may administer
17 the oath and examine under oath any person considered
18 necessary in gathering information and evidence and
19 may have that information and evidence reduced to
20 writing if considered necessary, and all related
21 expenses shall be paid from the fees.

22 Revised Law

23 Sec. 4001.008. COMMISSIONER AGENT FOR SERVICE OF
24 PROCESS. In the manner provided by Subchapter C, Chapter 804, the
25 commissioner is a corporation's or partnership's agent for service
26 of process in a legal proceeding against the corporation or
27 partnership if:

28 (1) the corporation or partnership is licensed to
29 engage in business in this state and does not appoint or maintain an
30 agent for service in this state;

31 (2) an agent for service cannot be found with
32 reasonable diligence; or

33 (3) the license of the corporation or partnership is
34 revoked. (V.T.I.C. Art. 21.07, Sec. 2(r).)

35 Source Law

36 (r) The commissioner is the corporation's or
37 partnership's agent for service of process in the
38 manner provided by Section 3, Article 1.36, of this
39 code in a legal proceeding against the corporation or
40 partnership if:

41 (1) the corporation or partnership
42 licensed to transact business in this state fails to
43 appoint or maintain an agent for service in this state;

44 (2) an agent for service cannot with

1 reasonable diligence be found; or
2 (3) the license of a corporation or
3 partnership is revoked.

4 Revised Law

5 Sec. 4001.009. REFERENCES TO OTHER LAW. (a) As referenced
6 in Section 4001.003(9), a reference to an agent in the following
7 laws includes a subagent without regard to whether a subagent is
8 specifically mentioned:

9 (1) Chapters 281, 523, 541-556, 558, 702, 703, 705,
10 821, 823-825, 827, 828, 844, 1108, 1205-1209, 1352, 1353, 1357,
11 1358, 1360-1363, 1369, 1453-1455, and 1503;

12 (2) Subchapter C, Chapter 521;

13 (3) Subchapter A, Chapter 557;

14 (4) Subchapter B, Chapter 805;

15 (5) Subchapter D, Chapter 1103;

16 (6) Subchapters B, C, D, and E, Chapter 1204,
17 excluding Sections 1204.153 and 1204.154;

18 (7) Subchapter B, Chapter 1366;

19 (8) Subchapters B, C, and D, Chapter 1367, excluding
20 Section 1367.053(c);

21 (9) Subchapters A, C, D, E, F, H, and I, Chapter 1451;

22 (10) Subchapter B, Chapter 1452;

23 (11) Sections 982.001, 982.002, 982.004, 982.052,
24 982.102, 982.103, 982.104, 982.106, 982.107, 982.108, 982.110,
25 982.111, and 982.112;

26 (12) Subchapters D, E, and F, Chapter 982;

27 (13) Section 1101.003(a); and

28 (14) Chapter 107, Occupations Code.

29 (b) As referenced in Section 4001.051(b), a person is the
30 agent of the insurer for which the act is done or risk is taken in
31 the manner provided by that subsection for purposes of the
32 liabilities, duties, requirements, and penalties provided by a law
33 listed in Subsection (a). (New.)

34 Revisor's Note

35 Section (a), V.T.I.C. Article 21.02, and Section

1 1A(9), V.T.I.C. Article 21.07, revised in relevant
2 part in this code as Sections 4001.051(b) and
3 4001.003(9), respectively, refer to "this chapter,"
4 meaning V.T.I.C. Chapter 21. Subchapter A, Chapter
5 21, addressing agents and other insurance
6 professionals, is revised in this title of this code,
7 but the logical organization of this code required
8 other provisions in Chapter 21 to be revised
9 elsewhere. For drafting convenience, the revised law
10 adds this section identifying all revised provisions
11 derived from Chapter 21 that are not included in this
12 title of this code. This section reflects a
13 comprehensive list of all those provisions, regardless
14 of whether a particular provision appears to be
15 relevant in context. An analysis of the relevance of
16 each particular provision is outside the scope of this
17 codification.

18 [Sections 4001.010-4001.050 reserved for expansion]

19 SUBCHAPTER B. ACTS CONSTITUTING ACTING AS AGENT;

20 CONSEQUENCES OF AGENT'S ACTIONS

21 Revised Law

22 Sec. 4001.051. ACTS CONSTITUTING ACTING AS AGENT. (a)
23 This section applies regardless of whether an insurer is
24 incorporated under the laws of this state or another state or a
25 foreign government.

26 (b) Regardless of whether the act is done at the request of
27 or by the employment of an insurer, broker, or other person, a
28 person is the agent of the insurer for which the act is done or risk
29 is taken for purposes of the liabilities, duties, requirements, and
30 penalties provided by this title, Chapter 21, or a provision listed
31 in Section 4001.009 if the person:

32 (1) solicits insurance on behalf of the insurer;

33 (2) receives or transmits other than on the person's
34 own behalf an application for insurance or an insurance policy to or

1 from the insurer;

2 (3) advertises or otherwise gives notice that the
3 person will receive or transmit an application for insurance or an
4 insurance policy;

5 (4) receives or transmits an insurance policy of the
6 insurer;

7 (5) examines or inspects a risk;

8 (6) receives, collects, or transmits an insurance
9 premium;

10 (7) makes or forwards a diagram of a building;

11 (8) takes any other action in the making or
12 consummation of an insurance contract for or with the insurer other
13 than on the person's own behalf; or

14 (9) examines into, adjusts, or aids in adjusting a
15 loss for or on behalf of the insurer.

16 (c) This section does not authorize an agent to orally, in
17 writing, or otherwise alter or waive a term or condition of an
18 insurance policy or an application for an insurance policy.

19 (d) The referral by an unlicensed person of a customer or
20 potential customer to an agent is not an act of an agent under this
21 section unless the unlicensed person discusses specific insurance
22 policy terms or conditions with the customer or potential customer.

23 (V.T.I.C. Art. 21.02, Secs. (a) (part), (b).)

24 Source Law

25 Art. 21.02. (a) Any person who solicits
26 insurance on behalf of any insurance company, whether
27 incorporated under the laws of this or any other state
28 or foreign government, or who takes or transmits other
29 than for himself any application for insurance or any
30 policy of insurance to or from such company, or who
31 advertises or otherwise gives notice that he will
32 receive or transmit the same, or who shall receive or
33 deliver a policy of insurance of any such company, or
34 who shall examine or inspect any risk, or receive, or
35 collect, or transmit any premium of insurance, or make
36 or forward any diagram of any building or buildings, or
37 do or perform any other act or thing in the making or
38 consummating of any contract of insurance for or with
39 any such insurance company other than for himself, or
40 who shall examine into, or adjust, or aid in adjusting,
41 any loss for or on behalf of any such insurance
42 company, whether any of such acts shall be done at the
43 instance or request, or by the employment of such

1 insurance company, or of, or by, any broker or other
2 person, shall be held to be the agent of the company
3 for which the act is done, or the risk is taken, as far
4 as relates to all the liabilities, duties,
5 requirements and penalties set forth in this chapter.
6 This article does not authorize an agent to orally, in
7 writing, or otherwise alter, amend, modify, waive, or
8 change a term or condition of an insurance policy or
9 application for an insurance policy. . . .

10 (b) The referral by an unlicensed person of a
11 customer or potential customer to a licensed insurance
12 agent is not an act of an agent under this article,
13 unless the unlicensed person discusses specific
14 insurance policy terms or conditions with the customer
15 or potential customer.

16 Revisor's Note

17 (1) Section (a), V.T.I.C. Article 21.02, refers
18 to acts done at the "instance or request" of an
19 insurer, broker, or other person. The reference to
20 "instance" is omitted from the revised law because
21 "instance" is included in the meaning of "request."

22 (2) Section (a), V.T.I.C. Article 21.02,
23 provides that the article does not authorize an agent
24 to "alter, amend, modify, waive, or change" a term or
25 condition of an insurance policy or application for an
26 insurance policy. The references to "modify,"
27 "amend," and "change" are omitted from the revised law
28 because those terms are included in the meaning of
29 "alter."

30 Revised Law

31 Sec. 4001.052. SOLICITOR OF APPLICATION FOR INSURANCE
32 CONSIDERED AGENT OF INSURER. (a) A person who solicits an
33 application for life, accident, or health insurance or property or
34 casualty insurance is considered the agent of the insurer issuing a
35 policy on the application and not the agent of the insured in any
36 controversy between the insurer and the insured, the insured's
37 beneficiary, or the insured's dependents.

38 (b) The agent may not alter or waive a term or condition of
39 the application or policy. (V.T.I.C. Art. 21.04.)

40 Source Law

41 Art. 21.04. Any person who solicits an
42 application for life, accident, or health insurance,

1 or property or casualty insurance, shall, in any
2 controversy between the insured or the insured's
3 beneficiary and the company issuing any policy upon
4 such application or between the insured or the
5 insured's dependents and that company, be regarded as
6 the agent of the company, and not the agent of the
7 insured, but such agent shall not have the power to
8 waive, change or alter any of the terms or conditions
9 of the application or policy.

10 Revisor's Note

11 V.T.I.C. Article 21.04 provides that an agent
12 does not have the power to "waive, change or alter" any
13 of the terms or conditions of an application for an
14 insurance policy or of a policy. The revised law omits
15 the reference to "change" because that term is
16 included in the meaning of "alter."

17 Revised Law

18 Sec. 4001.053. PERSONAL LIABILITY FOR ACTING AS AGENT. A
19 person who takes an action listed in Section 4001.051 for or on
20 behalf of an insurer before the insurer complies with the
21 requirements of the laws of this state is personally liable to the
22 holder of any insurance policy with respect to which the action was
23 taken for any loss covered by the insurance policy. (V.T.I.C. Art.
24 21.02, Sec. (a) (part).)

25 Source Law

26 (a) . . . Any person who shall do any of the
27 acts mentioned in this article for or on behalf of any
28 insurance company without such company having first
29 complied with the requirements of the laws of this
30 State, shall be personally liable to the holder of any
31 policy of insurance in respect of which such act was
32 done for any loss covered by the same.

33 Revised Law

34 Sec. 4001.054. LIABILITY OF AGENT AND INSURER FOR
35 TAXES. (a) If a person takes an action in this state listed in
36 Section 4001.051 for or on behalf of an insurer, the insurer is
37 considered to be engaged in the business of insurance in this state
38 and is subject to the same state, county, and municipal taxes as an
39 insurer that has been legally qualified and admitted to engage in
40 the business of insurance in this state.

41 (b) Taxes shall be assessed against and collected from an

1 insurer under this section in the same manner as taxes are assessed
2 against and collected from insurers that are legally qualified and
3 admitted to engage in the business of insurance in this state.

4 (c) A person who takes an action by means of which an insurer
5 is considered to be engaged in the business of insurance in this
6 state under this section is personally liable for any taxes
7 assessed against the insurer under this section. (V.T.I.C.
8 Art. 21.03.)

9 Source Law

10 Art. 21.03. Whenever any person shall do or
11 perform within this State any of the acts mentioned in
12 the preceding article for or on behalf of any insurance
13 company therein referred to, such company shall be
14 held to be doing business in this State and shall be
15 subject to the same taxes, state, county and
16 municipal, as insurance companies that have been
17 legally qualified and admitted to do business in this
18 State by agents or otherwise are subject, the same to
19 be assessed and collected as taxes are assessed and
20 collected against such companies; and such persons so
21 doing or performing any of such acts or things shall be
22 personally liable for such taxes.

23 Revisor's Note

24 V.T.I.C. Article 21.03 refers to insurers that
25 have been legally qualified and admitted to engage in
26 business in this state "by agents or otherwise." The
27 revised law omits the quoted language as unnecessary
28 because it is not a limitation and merely describes all
29 insurers authorized to engage in business in this
30 state.

31 [Sections 4001.055-4001.100 reserved for expansion]

32 SUBCHAPTER C. LICENSE REQUIREMENTS

33 Revised Law

34 Sec. 4001.101. LICENSE OR CERTIFICATE OF AUTHORITY
35 REQUIRED. (a) Unless the person holds a license or certificate of
36 authority issued by the department, a person may not:

37 (1) solicit or receive an application for insurance in
38 this state; or

39 (2) aid in the transaction of the business of an
40 insurer.

1 (b) A person may not act as an agent of a health maintenance
2 organization or other type of insurer authorized to engage in
3 business in this state unless the person holds a license issued by
4 the department as provided by this title.

5 (c) An insurer described by Subsection (b) may not appoint a
6 person to act as its agent unless the person holds a license under
7 this title.

8 (d) This subchapter does not permit an employee or agent of
9 a corporation or partnership to perform an act of an agent under
10 this title without obtaining a license. (V.T.I.C. Art. 21.01, Sec.
11 2; Art. 21.07, Secs. 1(a) (part), 2(j).)

12 Source Law

13 [Art. 21.01]

14 Sec. 2. It shall not be lawful for any person to
15 act, as an agent or otherwise, in soliciting or
16 receiving applications for insurance of any kind
17 whatever in this state, or in any manner to aid in the
18 transaction of the business of any insurance company
19 incorporated in this state, or out of it, without first
20 procuring a license or certificate of authority from
21 the department.

22 Art. 21.07

23 Sec. 1. (a) No person shall act as an agent of
24 any insurance company, health maintenance
25 organization, or other type of insurance carrier
26 licensed to do business in the State of Texas and which
27 insurance carrier's agents are required to be licensed
28 under the provisions of this code unless that person
29 shall have first procured a license from the
30 department as provided by this subchapter, and no such
31 insurance carrier shall appoint any person to act as
32 its agent unless such person shall have obtained a
33 license under the provisions of this subchapter,
34 and

35 [Sec. 2]

36 (j) Nothing contained in this section shall be
37 construed to permit any unlicensed employee or agent
38 of any corporation or partnership to perform any act of
39 an agent under this subchapter without obtaining a
40 license.

41 Revisor's Note

42 Section 2, V.T.I.C. Article 21.01, refers to any
43 insurance company "incorporated in this state, or out
44 of it," meaning any domestic or foreign insurer. The
45 revised law omits the quoted language as unnecessary.
46 The definition of insurer provided by Section 4001.003

1 includes any insurance company regulated by the Texas
2 Department of Insurance, regardless of whether the
3 company is domestic or foreign.

4 Revised Law

5 Sec. 4001.102. LICENSE APPLICATION. (a) To become an
6 agent for an insurer or health maintenance organization, a person
7 must submit to the department a completed license application in
8 the form required by the department.

9 (b) The commissioner by rule shall prescribe the
10 requirements for a properly completed application. (V.T.I.C.
11 Art. 21.07, Secs. 2(a), (b).)

12 Source Law

13 Sec. 2. (a) Any person that desires to become
14 an agent for an insurance company or health
15 maintenance organization, the agents of which are
16 required to be licensed under this subchapter, shall
17 submit to the department an application for a license
18 in the form required by the department.

19 (b) Each applicant for a license to act as an
20 insurance agent in this state shall file with the
21 department a completed application in the format
22 prescribed by the department. The commissioner shall
23 establish by rule the requirements for a properly
24 completed application.

25 Revised Law

26 Sec. 4001.103. FAILURE TO PROVIDE COMPLETE SET OF
27 FINGERPRINTS: GROUND FOR DENIAL OF APPLICATION. (a) In this
28 section, "authorization" means any authorization issued by the
29 department to engage in an activity regulated under this title,
30 including a license or permit.

31 (b) The department may deny an application for an
32 authorization if the applicant fails to provide a complete set of
33 fingerprints on request by the department. (V.T.I.C. Art. 1.10C
34 (part).)

35 Source Law

36 Art. 1.10C. The department may deny a license to
37 an applicant for any license, permit, or other
38 authorization issued by the board to engage in an
39 activity regulated under this code who fails to
40 provide a complete set of fingerprints on request
41 and

1 Revisor's Note

2 V.T.I.C. Article 1.10C refers to an authorization
3 to engage in an activity regulated under this "code."
4 The revised law refers to an authorization to engage in
5 an activity regulated under this "title" because, in
6 context, the provision applies only to activities
7 regulated under this title. An authorization to
8 engage in an activity regulated under another title of
9 this code is covered by Section 801.056 of this code.

10 Revised Law

11 Sec. 4001.104. ISSUANCE OF LICENSE: INTENT TO ACTIVELY
12 ENGAGE IN BUSINESS OF INSURANCE FOR GENERAL PUBLIC. (a) The
13 department may not issue a license as an agent to write any line of
14 insurance unless the department determines that:

15 (1) the applicant is or intends to be actively engaged
16 in the soliciting or writing of insurance for the general public and
17 is to be actively engaged in the business of insurance; and

18 (2) the application is not made to evade the laws
19 against rebating and discrimination, either for the applicant or
20 for another person.

21 (b) This subchapter does not prohibit an applicant from
22 insuring property that the applicant owns or in which the applicant
23 has an interest. It is the intent of this subchapter to prohibit
24 coercion of insurance and to preserve to each individual the right
25 to choose that individual's own agent or insurer and to prohibit the
26 licensing of an applicant to engage in the business of insurance
27 principally to handle business that the applicant controls only
28 through ownership, mortgage, sale, family relationship, or
29 employment. An applicant for an original license must have a bona
30 fide intention to engage in business in which, in any calendar year,
31 at least 25 percent of the total volume of premiums is derived from
32 persons other than the applicant and from property other than that
33 on which the applicant controls the placing of insurance through
34 ownership, mortgage, sale, family relationship, or employment.

1 (c) The department may not deny a license application solely
2 on the ground that the applicant will act only part-time as an
3 agent. (V.T.I.C. Art. 21.07, Secs. 2(c), (d), (e).)

4 Source Law

5 (c) The department may not grant a license as an
6 insurance agent to write any form of insurance unless
7 the department finds that:

8 (1) the applicant is or intends to be
9 actively engaged in the soliciting or writing of
10 insurance for the public generally and is to be
11 actively engaged in the business of insurance; and

12 (2) the application is not made to evade
13 the laws against rebating and discrimination, either
14 for the applicant or for some other person.

15 (d) This section does not prohibit an applicant
16 from insuring property that the applicant owns or in
17 which the applicant has an interest, but it is the
18 intent of this section to prohibit coercion of
19 insurance and to preserve to each individual the right
20 to choose that individual's own agent or insurance
21 company, and to prohibit the licensing of a person to
22 engage in the insurance business principally to handle
23 business that the applicant controls only through
24 ownership, mortgage or sale, family relationship, or
25 employment. An applicant for an original license must
26 have a bona fide intention to engage in business in
27 which, in any calendar year, at least 25 percent of the
28 total volume of premiums is derived from persons other
29 than the applicant and from property other than that on
30 which the applicant controls the placing of insurance
31 through ownership, mortgage, sale, family
32 relationship, or employment.

33 (e) The department may not deny a license
34 application solely on the ground that the applicant
35 will act only part-time as an agent.

36 Revised Law

37 Sec. 4001.105. ISSUANCE OF LICENSE TO INDIVIDUAL. The
38 department shall issue a license to an individual to engage in
39 business as an agent if the department determines that the
40 individual:

41 (1) is at least 18 years of age;

42 (2) has passed the licensing examination required
43 under this code within the past 12 months;

44 (3) has not committed an act for which a license may be
45 denied under Subchapter C, Chapter 4005; and

46 (4) has submitted the application, appropriate fees,
47 and any other information required by the department. (V.T.I.C.
48 Art. 21.07, Sec. 2(f).)

1 (4) if engaged in the business of insurance, the
2 corporation or partnership intends to be actively engaged in that
3 business as required under Section 4001.104(a);

4 (5) each location from which the corporation or
5 partnership will engage in business in this state under authority
6 of a license issued by the department is registered separately with
7 the department;

8 (6) the corporation or partnership has submitted the
9 application, appropriate fees, and any other information required
10 by the department; and

11 (7) an officer, director, member, manager, partner, or
12 other person who has the right or ability to control the corporation
13 or partnership has not:

14 (A) had a license suspended or revoked or been
15 the subject of any other disciplinary action by a financial or
16 insurance regulator of this state, another state, or the United
17 States; or

18 (B) committed an act for which a license may be
19 denied under Subchapter C, Chapter 4005.

20 (c) A corporation or partnership shall maintain the ability
21 to pay a claim described by Subsection (b)(3) by obtaining:

22 (1) an errors and omissions policy insuring the
23 corporation or partnership against errors and omissions in at least
24 the amount of \$250,000, with a deductible of not more than 10
25 percent of the full amount of the policy, issued by:

26 (A) an insurer authorized to engage in the
27 business of insurance in this state; or

28 (B) if a policy cannot be obtained from an
29 insurer authorized to engage in the business of insurance in this
30 state, a surplus lines insurer under Chapter 981; or

31 (2) a bond in the principal amount of \$25,000 that is:

32 (A) executed by the corporation or partnership as
33 principal and a surety company authorized to engage in business in
34 this state as surety;

1 (B) payable to the department for the use and
2 benefit of customers of the corporation or partnership; and

3 (C) conditioned that the corporation or
4 partnership shall pay any final judgment recovered against it by a
5 customer.

6 (d) A binding commitment to issue a policy or bond described
7 by Subsection (c) is sufficient in connection with an application
8 for a license. (V.T.I.C. Art. 21.07, Sec. 2(i) (part).)

9 Source Law

10 (i) The department shall issue a license to a
11 corporation or partnership if the department finds
12 that:

13 (1) the corporation or partnership is:

14 (A) organized under the laws of this
15 state or any other state or territory of the United
16 States;

17 (B) admitted to conduct business in
18 this state by the secretary of state, if so required;
19 and

20 (C) authorized by its articles of
21 incorporation or its partnership agreement to act as
22 an insurance agent;

23 . . .
24 (3) at least one officer of the
25 corporation or one active partner of the partnership
26 and all other persons performing any acts of an agent
27 on behalf of the corporation or partnership in this
28 state are individually licensed by the department
29 separately from the corporation or partnership;

30 (4) the corporation or partnership will
31 have the ability to pay any sums up to \$25,000 which it
32 might become legally obligated to pay on account of any
33 claim made against it by any customer and caused by any
34 negligent act, error, or omission of the corporation
35 or partnership or any person for whose acts the
36 corporation or partnership is legally liable in the
37 conduct of its business under this code. The term
38 "customer" means any person, firm, or corporation to
39 whom such corporation or partnership sells or attempts
40 to sell a policy of insurance, or from whom such
41 corporation or partnership accepts an application for
42 insurance. Such ability shall be maintained in one of
43 the following ways:

44 (A) an errors and omissions policy
45 insuring such corporation or partnership against
46 errors and omissions in at least the sum of \$250,000
47 with a deductible of not more than 10 percent of the
48 full amount of the policy issued by an insurance
49 company licensed to do business in this state or, if a
50 policy cannot be obtained from a company licensed to do
51 business in this state, a surplus lines insurance
52 policy issued under Article 1.14-2 of this code; or

53 (B) a bond executed by such
54 corporation or partnership as principal and a surety
55 company authorized to do business in this state, as
56 surety, in the principal sum of \$25,000, payable to the
57 department for the use and benefit of customers of such
58 corporation or partnership, conditioned that such

1 corporation or partnership shall pay any final
2 judgment recovered against it by any customer. A
3 binding commitment to issue such a policy or bond shall
4 be sufficient in connection with any application for
5 license;

6 (5) the corporation or partnership intends
7 to be actively engaged in the business of insurance as
8 required under Subsection (c) of this section;

9 (6) each location from which the
10 corporation or partnership will conduct its business
11 in this state under authority of an insurance license
12 is separately registered with the department;

13 (7) the corporation or partnership has
14 submitted the application, appropriate fees, and any
15 other information required by the department; and

16 (8) an officer, director, member, manager,
17 partner, or any other person who has the right or
18 ability to control the license holder has not:

19 (A) had a license suspended or
20 revoked or been the subject of any other disciplinary
21 action by a financial or insurance regulator of this
22 state, another state, or the United States; or

23 (B) committed an act for which a
24 license may be denied under Article 21.01-2 of this
25 code.

26 Revisor's Note

27 (1) Section 2(i)(2), V.T.I.C. Article 21.07,
28 requires the Texas Department of Insurance to issue a
29 license to a corporation or partnership if the
30 department finds that the corporation or partnership
31 meets the definition of that entity adopted under
32 Section 1A of that article. Sections 1A(3) and (7),
33 V.T.I.C. Article 21.07, revised as Sections
34 4001.003(3) and (7), respectively, define
35 "corporation" and "partnership," respectively.
36 Because the definitions apply to this section by their
37 terms, the revised law omits Section 2(i)(2), V.T.I.C.
38 Article 21.07. The omitted law reads:

39 [(i) The department shall issue a
40 license to a corporation or partnership if
41 the department finds that:]

42 . . .
43 (2) the corporation or
44 partnership meets the definition of that
45 entity adopted under Section 1A of this
46 article;
47 . . .

48 (2) Section 2(i)(4), V.T.I.C. Article 21.07,
49 refers to a "person, firm, or corporation." The
50 revised law omits the reference to "corporation" as

1 unnecessary because under Section 1A(8), V.T.I.C.
2 Article 21.07, revised as Section 4001.003(8),
3 "person" is defined to include "corporation."

4 Revised Law

5 Sec. 4001.107. ISSUANCE OF LICENSE TO DEPOSITORY
6 INSTITUTION. The department shall issue a license to a depository
7 institution in the manner provided by this subchapter for the
8 licensing of a corporation. (V.T.I.C. Art. 21.07, Sec. 2(m).)

9 Source Law

10 (m) The department shall issue a license to a
11 depository institution in the manner provided for the
12 licensing of a corporation under this section.

13 Revised Law

14 Sec. 4001.108. ISSUANCE OF LICENSE TO ENTITY CHARTERED BY
15 FEDERAL FARM CREDIT ADMINISTRATION. The department may license an
16 entity chartered by the federal Farm Credit Administration under
17 the farm credit system established under 12 U.S.C. Section 2001 et
18 seq., as amended, to solicit insurance in this state as provided by
19 12 U.S.C. Section 2218, as amended. The department shall issue the
20 license in the manner provided by this subchapter for the licensing
21 of a corporation. (V.T.I.C. Art. 21.07, Sec. 2(v).)

22 Source Law

23 (v) An entity chartered by the federal Farm
24 Credit Administration under the farm credit system
25 established under 12 U.S.C. Section 2001 et seq., as
26 amended, may be licensed by the department to solicit
27 insurance in this state, as provided by 12 U.S.C.
28 Section 2218, as amended, and in the manner provided
29 for the licensing of a corporation under this section.

30 Revised Law

31 Sec. 4001.109. LICENSING OF SUBAGENT. A subagent must be
32 licensed to write each line of insurance that the subagent is
33 employed to write, but is not required to hold each kind of license
34 issued to the agent for whom the subagent acts. (V.T.I.C. Art.
35 21.07, Sec. 2(u).)

36 Source Law

37 (u) A subagent must be licensed to write each
38 type of insurance that the subagent is employed to
39 write, but the subagent is not required to hold each

1 type of license issued to the agent for whom the
2 subagent acts.

3 [Sections 4001.110-4001.150 reserved for expansion]

4 SUBCHAPTER D. TEMPORARY LICENSE

5 Revised Law

6 Sec. 4001.151. AUTHORITY TO ISSUE TEMPORARY LICENSE. The
7 department may issue a temporary agent's license to an applicant
8 for a license under Section 4001.102 who is being considered for
9 appointment as an agent by another agent, an insurer, or a health
10 maintenance organization. (V.T.I.C. Art. 21.07, Sec. 3A(a)
11 (part).)

12 Source Law

13 Sec. 3A. (a) The department may issue a
14 temporary agent's license to an applicant for a license
15 under Section 2 of this article who is being considered
16 for appointment as an agent by another license holder,
17 an insurer, or a health maintenance
18 organization. . . .

19 Revised Law

20 Sec. 4001.152. EXAMINATION NOT REQUIRED. An applicant is
21 not required to pass a written examination to obtain a temporary
22 license. (V.T.I.C. Art. 21.07, Sec. 3A(a) (part).)

23 Source Law

24 (a) . . . An applicant for a temporary license
25 is not required to pass a written examination. . . .

26 Revised Law

27 Sec. 4001.153. APPLICATION FOR AND ISSUANCE OF TEMPORARY
28 LICENSE. The department shall issue a temporary license
29 immediately on receipt of a properly completed application executed
30 by the applicant in the form required by Section 4001.102 and
31 accompanied by:

32 (1) the nonrefundable filing fee set by the
33 department; and

34 (2) a certificate signed by an officer or properly
35 authorized representative of an agent, insurer, or health
36 maintenance organization stating that:

37 (A) the applicant is being considered for
38 appointment by the agent, insurer, or health maintenance

1 organization as its full-time agent;

2 (B) the agent, insurer, or health maintenance
3 organization desires that the applicant be issued a temporary
4 license; and

5 (C) the applicant will complete training as
6 prescribed by Section 4001.160 under the agent's, insurer's, or
7 health maintenance organization's supervision. (V.T.I.C. Art.
8 21.07, Sec. 3A(a) (part).)

9 Source Law

10 (a) . . . The department shall issue a
11 temporary license immediately on receipt by the
12 department of a properly completed application
13 executed by the person in the form required by Section
14 2 of this article, accompanied by the nonrefundable
15 filing fee set by the department and a certificate
16 signed by an officer or properly authorized
17 representative of the agent, insurer, or health
18 maintenance organization stating that:

19 (1) the applicant is being considered for
20 appointment by the agent, insurer, or health
21 maintenance organization as its full-time agent;

22 (2) the agent, insurer, or health
23 maintenance organization desires that the applicant be
24 issued a temporary license; and

25 (3) the applicant will complete, under the
26 agent's, insurer's, or health maintenance
27 organization's supervision, . . . training as
28 prescribed by Subsection (h) of this section

29 Revised Law

30 Sec. 4001.154. AUTHORITY TO ACT AS AGENT PENDING RECEIPT OF
31 TEMPORARY LICENSE. If a temporary license is not received from the
32 department before the eighth day after the date the application,
33 nonrefundable fee, and certificate are delivered or mailed to the
34 department and the appropriate agent, insurer, or health
35 maintenance organization has not been notified that the application
36 is denied, the agent, insurer, or health maintenance organization
37 may assume that the temporary license will be issued and the
38 applicant may proceed to act as an agent. (V.T.I.C. Art. 21.07,
39 Sec. 3A(b).)

40 Source Law

41 (b) If the temporary license is not received
42 from the department before the eighth day after the
43 date on which the application, certificate, and
44 nonrefundable fee are delivered or mailed to the
45 department and the agent, insurer, or health

1 maintenance organization has not been notified that
2 the application is denied, the agent, insurer, or
3 health maintenance organization may assume that the
4 temporary license will be issued and the applicant may
5 proceed to act as an agent.

6 Revised Law

7 Sec. 4001.155. TERM OF TEMPORARY LICENSE. A temporary
8 license is valid for 90 days after the date of issuance. (V.T.I.C.
9 Art. 21.07, Sec. 3A(a) (part).)

10 Source Law

11 (a) . . . A temporary license is valid for the
12 90 days after the date of issuance. . . .

13 Revised Law

14 Sec. 4001.156. RESTRICTION ON ISSUANCE OR RENEWAL OF
15 TEMPORARY LICENSE. (a) A temporary license may not be issued to
16 or renewed by the same person more than once in a consecutive
17 six-month period.

18 (b) A temporary license may not be issued to a person who
19 does not intend to apply for a license to sell insurance or
20 memberships to the general public. (V.T.I.C. Art. 21.07, Secs.
21 3A(c), (d).)

22 Source Law

23 (c) A temporary license may not be renewed or
24 issued more than once in a consecutive six-month
25 period to the same applicant.

26 (d) A temporary license may not be granted to a
27 person who does not intend to apply for a license to
28 sell insurance or memberships to the public generally.

29 Revised Law

30 Sec. 4001.157. OBTAINING CERTAIN COMMISSIONS PROHIBITED.

31 (a) A temporary license holder may not obtain a commission on a
32 sale made to a person who has a family, employment, or business
33 relationship with the temporary license holder.

34 (b) An agent, insurer, or health maintenance organization
35 may not knowingly pay, directly or indirectly, to a temporary
36 license holder, and a temporary license holder may not receive or
37 accept, a commission on the sale of a contract of insurance or
38 membership covering:

39 (1) the temporary license holder;

1 (2) a person related to the temporary license holder
2 by consanguinity or affinity;

3 (3) a person who is or has been during the past six
4 months the temporary license holder's employer, either as an
5 individual or as a member of a partnership, association, firm, or
6 corporation; or

7 (4) a person who is or has been during the past six
8 months an employee of the temporary license holder. (V.T.I.C. Art.
9 21.07, Sec. 3A(e).)

10 Source Law

11 (e) A temporary license may not be used to
12 obtain commissions from sales made to persons who have
13 family, employment, or business relationships with the
14 temporary license holder. An agent, insurer, or
15 health maintenance organization may not knowingly pay,
16 directly or indirectly, to the holder of a temporary
17 license under this section, and a temporary license
18 holder may not receive or accept, a commission on the
19 sale of a contract of insurance or membership
20 covering:

- 21 (1) the temporary license holder;
22 (2) a person related to the temporary
23 license holder by consanguinity or affinity;
24 (3) a person who is or has been during the
25 past six months the temporary license holder's
26 employer, either as an individual or as a member of a
27 partnership, association, firm, or corporation; or
28 (4) a person who is or who has been during
29 the past six months the employee of the temporary
30 license holder.

31 Revised Law

32 Sec. 4001.158. REPLACEMENT OF EXISTING LIFE INSURANCE OR
33 ANNUITY CONTRACT PROHIBITED. (a) A temporary license holder who
34 is acting under the authority of that license may not:

35 (1) engage in an insurance solicitation, sale, or
36 other agency transaction that the license holder knows or should
37 know will result or is intended to result in:

38 (A) the purchase of a new life insurance or
39 annuity contract; and

40 (B) any of the following actions with regard to
41 an existing individual life insurance or annuity contract as a
42 result of that purchase:

43 (i) termination of the contract by lapse,

1 forfeiture, surrender, or other means;

2 (ii) conversion of the contract to reduced
3 paid-up insurance, continuation of the contract as extended term
4 insurance, or reduction in value of the contract by the use of
5 nonforfeiture benefits or other policy values;

6 (iii) amendment of the contract to reduce:

7 (a) benefits; or

8 (b) the term for which coverage would
9 otherwise remain in force or for which benefits would be paid;

10 (iv) reissuance of the contract with a
11 reduction in cash value; or

12 (v) pledge of the contract as collateral or
13 subjection of the contract to borrowing, whether in a single loan or
14 under a schedule of borrowing, for amounts that in the aggregate
15 exceed 25 percent of the loan value prescribed by the contract; or

16 (2) directly or indirectly receive a commission or
17 other compensation that results or may result from a solicitation,
18 sale, or other agency transaction described by Subdivision (1).

19 (b) A person who holds a permanent license may not
20 circumvent or attempt to circumvent the intent of this section by
21 acting for or with a person holding a temporary license. (V.T.I.C.
22 Art. 21.07, Sec. 3A(f).)

23 Source Law

24 (f) A person who has been issued a temporary
25 license under this section and is acting under the
26 authority of the temporary license may not engage in
27 any insurance solicitation, sale, or other agency
28 transaction that results in or is intended to result in
29 the replacement of any existing individual life
30 insurance policy form or annuity contract that is in
31 force, or receive, directly or indirectly, any
32 commission or other compensation that may or does
33 result from such a solicitation, sale, or other agency
34 transaction. A person who holds a permanent license
35 may not circumvent or attempt to circumvent the intent
36 of this subsection by acting for or with a person
37 holding a temporary license. As used in this
38 subsection, "replacement" means a transaction in which
39 a new life insurance or annuity contract is to be
40 purchased, and it is known or should be known to the
41 temporary agent that by reason of the solicitation,
42 sale, or other transaction the existing life insurance
43 or annuity contract has been or is to be:

44 (1) lapsed, forfeited, surrendered, or

1 otherwise terminated;

2 (2) converted to reduced paid-up
3 insurance, continued as extended term insurance, or
4 otherwise reduced in value by the use of nonforfeiture
5 benefits or other policy values;

6 (3) amended so as to effect either a
7 reduction in benefits or in the term for which coverage
8 would otherwise remain in force or for which benefits
9 would be paid;

10 (4) reissued with any reduction in cash
11 value; or

12 (5) pledged as collateral or subjected to
13 borrowing, whether in a single loan or under a schedule
14 of borrowing over a period of time, for amounts in the
15 aggregate exceeding 25 percent of the loan value set
16 forth in the policy.

17 Revisor's Note

18 Section 3A(f)(5), V.T.I.C. Article 21.07, refers
19 to a "schedule of borrowing over a period of time."
20 The revised law omits "over a period of time" because
21 "over a period of time" is included within the meaning
22 of "schedule."

23 Revised Law

24 Sec. 4001.159. SUSPENSION OR REVOCATION OF TEMPORARY
25 APPOINTMENT POWERS OF AGENT, INSURER, OR HEALTH MAINTENANCE
26 ORGANIZATION. (a) The department may suspend or revoke the
27 temporary appointment powers of an agent, insurer, or health
28 maintenance organization if, after notice and opportunity for
29 hearing, the department determines that the agent, insurer, or
30 health maintenance organization has abused the temporary
31 appointment powers.

32 (b) In determining whether abuse has occurred, the
33 department may consider:

34 (1) the number of temporary appointments made;

35 (2) the percentage of appointees taking the
36 examination required for licensing as an agent, as provided by
37 Section 4001.161; and

38 (3) the number of appointees who pass the examination.

39 (V.T.I.C. Art. 21.07, Sec. 3A(g) (part).)

40 Source Law

41 (g) The department may cancel, suspend, or
42 revoke the temporary appointment powers of an agent,
43 insurer, or health maintenance organization if, after

1 notice and opportunity for hearing, the commissioner
2 finds that that agent, insurer, or health maintenance
3 organization has abused the temporary appointment
4 powers. . . . In considering whether abuse has
5 occurred, the department may consider:

6 (1) the number of temporary appointments
7 made;

8 (2) the percentage of appointees sitting
9 for examination as agents under this article, as
10 provided by Subsection (j) of this section; and

11 (3) the number of appointees who pass the
12 examination.

13 Revisor's Note

14 (1) Section 3A(g), V.T.I.C. Article 21.07,
15 allows the department to "cancel, suspend, or revoke"
16 the temporary appointment powers of an agent, insurer,
17 or health maintenance organization. The revised law
18 omits the reference to "cancel" as unnecessary
19 because, in this context, "cancel" is included in the
20 meaning of "revoke."

21 (2) Section 3A(g), V.T.I.C. Article 21.07,
22 provides that an appeal from department action under
23 that section is subject to Chapter 36 of this code.
24 The revised law omits that provision as redundant
25 because Chapter 36 applies by its own terms, and an
26 additional statement to that effect in this chapter is
27 unnecessary. The omitted law reads:

28 (g) . . . An appeal from the
29 department's decision is subject to Chapter
30 36 of this code. . . .

31 Revised Law

32 Sec. 4001.160. TRAINING OF APPLICANT FOR TEMPORARY LICENSE.

33 (a) An agent, insurer, or health maintenance organization that is
34 considering appointment of a temporary license applicant as its
35 agent shall provide at least 40 hours of training to the applicant
36 not later than the 14th day after the date the application,
37 nonrefundable fee, and certificate are delivered or mailed to the
38 department.

39 (b) At least 10 hours of the training must be taught in a
40 classroom setting, including:

41 (1) an accredited college, university, junior

1 college, or community college;

2 (2) a business school; or

3 (3) a private institute or classes sponsored by the
4 agent, insurer, or health maintenance organization and
5 specifically established for that purpose.

6 (c) The training program must be designed to provide an
7 applicant with basic knowledge of:

8 (1) the broad principles of insurance, including the
9 licensing and regulatory laws of this state;

10 (2) the broad principles of health maintenance
11 organizations, including membership requirements and related
12 licensing and regulatory laws of this state; and

13 (3) the ethical obligations and duties of an agent.

14 (d) If the department determines under Section 4001.159
15 that an abuse of temporary appointment powers has occurred, the
16 department may require the affected agent, insurer, or health
17 maintenance organization to:

18 (1) file with the department a description of the
19 agent's, insurer's, or health maintenance organization's training
20 program; and

21 (2) obtain the approval of the department before
22 continuing to use the training program. (V.T.I.C. Art. 21.07,
23 Secs. 3A(a) (part), (h), (i).)

24 Source Law

25 (a) . . .
26 (3) [the applicant will complete] . . . at
27 least 40 hours of training [as prescribed by
28 Subsection (h) of this section] not later than the 14th
29 day after the date on which the application,
30 certificate, and nonrefundable fee are delivered or
31 mailed to the department.

32 (h) The agent, insurer, or health maintenance
33 organization shall administer at least 40 hours of
34 training to each applicant for a temporary license not
35 later than the 14th day after the date on which the
36 application, certificate, and nonrefundable fee are
37 delivered or mailed to the department. At least 10
38 hours must be taught in a classroom setting, including
39 an accredited college, university, junior college, or
40 community college, a business school, or a private
41 institute or classes sponsored by the agent, insurer,
42 or health maintenance organization and especially

1 established for this purpose. The training program
2 must be designed to provide an applicant with basic
3 knowledge of:

4 (1) the broad principles of insurance,
5 including the licensing and regulatory laws of this
6 state;

7 (2) the broad principles of health
8 maintenance organizations, including membership
9 requirements and related licensing and regulatory laws
10 of this state; and

11 (3) the ethical obligations and duties of
12 an agent.

13 (i) If the commissioner finds under Subsection
14 (g) of this section that an abuse of temporary
15 appointment powers has occurred, the commissioner may
16 require the affected agent, insurer, or health
17 maintenance organization to file with the department a
18 description of the agent's, insurer's, or health
19 maintenance organization's training program and may
20 require the agent, insurer, or health maintenance
21 organization to obtain the approval of the department
22 before continuing to use the training program.

23 Revised Law

24 Sec. 4001.161. DUTY TO ENSURE THAT APPLICANTS TAKE
25 LICENSING EXAMINATION. An agent, insurer, or health maintenance
26 organization shall ensure that, during any two consecutive calendar
27 quarters, at least 70 percent of the agent's, insurer's, or health
28 maintenance organization's applicants for temporary licenses take
29 the required licensing examination. At least 50 percent of the
30 applicants taking the examination must pass the examination during
31 that period. (V.T.I.C. Art. 21.07, Sec. 3A(j).)

32 Source Law

33 (j) Each agent, insurer, or health maintenance
34 organization shall ensure that, during any two
35 consecutive calendar quarters, at least 70 percent of
36 the agent's, insurer's, or health maintenance
37 organization's applicants for temporary licenses sit
38 for the required licensing examination. At least 50
39 percent of the applicants taking the examination must
40 pass during that period.

41 Revised Law

42 Sec. 4001.162. RESTRICTION ON APPOINTMENT OF TEMPORARY
43 LICENSE HOLDERS. An agent, insurer, or health maintenance
44 organization may not appoint more than 250 temporary license
45 holders during a calendar year. (V.T.I.C. Art. 21.07, Sec. 3A(k).)

46 Source Law

47 (k) An agent, insurer, or health maintenance
48 organization may not make more than 250 appointments
49 of temporary license holders during a calendar year.

1 [Sections 4001.163-4001.200 reserved for expansion]

2 SUBCHAPTER E. APPOINTMENT OF AGENT

3 Revised Law

4 Sec. 4001.201. APPOINTMENT REQUIRED. A person who obtains
5 a license under this title may not engage in business as an agent
6 unless the person has been appointed to act as an agent by an
7 insurer designated by the provisions of this code and authorized to
8 engage in business in this state. (V.T.I.C. Art. 21.07, Sec. 1(a)
9 (part).)

10 Source Law

11 (a) . . . no such person who obtains a license
12 shall engage in business as an agent until that person
13 shall have been appointed to act as an agent by some
14 duly authorized insurance carrier designated by the
15 provisions of this code and authorized to do business
16 in the State of Texas.

17 Revised Law

18 Sec. 4001.202. APPOINTMENT BY MULTIPLE INSURERS. (a)
19 Except as specifically prohibited by this code, an agent may
20 represent and act as an agent for more than one insurer.

21 (b) Not later than the 30th day after the effective date of
22 the appointment, the agent and the insurer involved shall notify
23 the department, on a form prescribed by the department, of any
24 additional appointment authorizing the agent to act as agent for
25 one or more additional insurers. The notice must be accompanied by
26 a nonrefundable fee in an amount set by the department for each
27 additional appointment for which the insurer applies. (V.T.I.C.
28 Art. 21.07, Sec. 6(a).)

29 Source Law

30 Sec. 6. (a) Except as specifically prohibited
31 by another provision of this code, an agent licensed
32 under this subchapter may represent and act as an agent
33 for more than one insurance carrier at any time while
34 the agent's license is in force, if the agent so
35 desires. Any such agent and the insurance carrier
36 involved shall notify the department, in a form
37 prescribed by the department, of any additional
38 appointment authorizing the agent to act as agent for
39 an additional insurance carrier or carriers not later
40 than the 30th day after the effective date of the
41 appointment. The filing must include a nonrefundable
42 fee in an amount determined by the commissioner for
43 each additional appointment for which the insurance

1 carrier applies.

2 Revisor's Note

3 Section 6(a), V.T.I.C. Article 21.07, provides
4 that a licensed agent may act as an agent for more than
5 one insurer "while the agent's license is in force."
6 The revised law omits the quoted language as
7 unnecessary because, as explained in Revisor's Note
8 (4) to Section 4001.002, an agent whose license is not
9 in force is not authorized to act for even a single
10 insurer.

11 Revised Law

12 Sec. 4001.203. TERM OF APPOINTMENT. (a) An appointment
13 authorizing an agent to act for an insurer continues in effect
14 without the necessity of renewal until the appointment is
15 terminated or withdrawn by the insurer or the agent.

16 (b) A renewal license issued to an agent authorizes the
17 agent to represent and act for each insurer for which the agent
18 holds an appointment until the appointment is terminated or
19 withdrawn, and the agent is considered to be the agent of each
20 appointing insurer for the purposes of this code. (V.T.I.C. Art.
21 21.07, Sec. 6(b) (part).)

22 Source Law

23 (b) An appointment made under this Article to
24 authorize an agent to act as an agent for an insurance
25 carrier continues in effect without the necessity of
26 renewal until it is terminated or withdrawn by the
27 insurance carrier or agent. . . . Each renewal
28 license issued to the agent authorizes the agent to
29 represent and act for the insurance carriers for which
30 the agent holds an appointment until the appointment
31 is terminated or withdrawn, and that agent is
32 considered to be the agent of the appointing insurance
33 carriers for the purposes of this code.

34 Revised Law

35 Sec. 4001.204. AUTHORITY TO ACT AS AGENT BEFORE NOTICE OF
36 APPOINTMENT. An agent appointed under this subchapter may act on
37 behalf of the appointing insurer before the department receives the
38 notice filed under Section 4001.202(b). (V.T.I.C. Art. 21.07, Sec.
39 6(c).)

1 Revisor's Note

2 (1) Section 6(d), V.T.I.C. Article 21.07,
3 requires an agent to notify the Texas Department of
4 Insurance of the appointment of a subagent "in writing
5 on a form prescribed by the department." The revised
6 law omits the requirement that the notification be
7 made "in writing" because notification provided on a
8 form is necessarily in writing.

9 (2) Section 6(e), V.T.I.C. Article 21.07,
10 refers to a subagent "who has been designated in
11 writing to the department as a subagent by an agent."
12 The revised law refers to a subagent "who has been
13 designated by an agent in a notice filed with the
14 department under Subsection (a)" because that
15 subsection governs the manner in which the designation
16 is made.

17 Revised Law

18 Sec. 4001.206. TERMINATION OF APPOINTMENT OF AGENT FOR
19 CAUSE; LIABILITY. (a) On termination of the appointment of an
20 agent for cause, the insurer or agent shall immediately file with
21 the department a statement of the facts relating to the termination
22 of the appointment and the date and cause of the termination. On
23 receipt of the statement, the department shall record the
24 termination of the appointment of that agent to represent the
25 insurer in this state.

26 (b) A document, record, statement, or other information
27 required to be made or disclosed to the department under this
28 section is a privileged and confidential communication and is not
29 admissible in evidence in a court action or proceeding except under
30 a subpoena issued by a court of record.

31 (c) A person, including an insurer or an employee or agent
32 of an insurer, who provides without malice information required to
33 be disclosed under this section is not liable for providing the
34 information. (V.T.I.C. Art. 21.07, Secs. 6(b) (part), 6B.)

1 who are in control of the corporation, or any other
2 partners who have the right or ability to control the
3 partnership. If any corporation or partnership is
4 owned, in whole or in part, by another entity, a
5 biographical form is required for each individual who
6 is in control of the parent entity.

7 (1) Each corporation or partnership shall
8 notify the department not later than the 30th day after
9 the date of:

10 (1) a felony conviction of a licensed
11 agent of the entity or any individual associated with
12 the corporation or partnership who is required to file
13 biographical information with the department;

14 (2) an event that would require
15 notification under Section 81.003 of this code; and

16 (3) the addition or removal of an officer,
17 director, partner, member, or manager.

18 Revised Law

19 Sec. 4001.253. RESTRICTION ON ACQUISITION OF OWNERSHIP
20 INTEREST IN ENTITY LICENSED AS AGENT. (a) A person may not acquire
21 in any manner an ownership interest in an entity licensed as an
22 agent under this title if the person is, or after the acquisition
23 would be, directly or indirectly in control of the license holder,
24 or otherwise acquire control of or exercise any control over the
25 license holder, unless the person has filed with the department
26 under oath:

27 (1) a biographical form for each person by whom or on
28 whose behalf the acquisition of control is to be effected;

29 (2) a statement certifying that no person who is
30 acquiring an ownership interest in or control of the license holder
31 has been the subject of a disciplinary action taken by a financial
32 or insurance regulator of this state, another state, or the United
33 States;

34 (3) a statement certifying that, immediately on the
35 change of control, the license holder will be able to satisfy the
36 requirements for the issuance of the license to solicit each line of
37 insurance for which it is licensed; and

38 (4) any additional information that the commissioner
39 by rule may prescribe as necessary or appropriate to the protection
40 of the insurance consumers of this state or as in the public
41 interest.

42 (b) The department may require a partnership, syndicate, or

1 other group that is required to file a statement under Subsection
2 (a) to provide the information under that subsection for each
3 partner of the partnership, each member of the syndicate or group,
4 and each person who controls the partner or member. If the partner,
5 member, or person is a corporation or the person required to file
6 the statement under Subsection (a) is a corporation, the department
7 may require that the information required under that subsection be
8 provided regarding:

9 (1) the corporation;

10 (2) each individual who is an executive officer or
11 director of the corporation; and

12 (3) each person who is directly or indirectly the
13 beneficial owner of more than 10 percent of the outstanding voting
14 securities of the corporation.

15 (c) The department may disapprove an acquisition of control
16 if, after notice and opportunity for hearing, the commissioner
17 determines that:

18 (1) immediately on the change of control the license
19 holder would not be able to satisfy the requirements for the
20 issuance of the license to solicit each line of insurance for which
21 it is presently licensed;

22 (2) the competence, trustworthiness, experience, and
23 integrity of the persons who would control the operation of the
24 license holder are such that it would not be in the interest of the
25 insurance consumers of this state to permit the acquisition of
26 control; or

27 (3) the acquisition of control would violate this code
28 or another law of this state, another state, or the United States.

29 (d) Notwithstanding Subsection (c), a change in control is
30 considered approved if the department has not proposed to deny the
31 requested change before the 61st day after the date the department
32 receives all information required by this section. (V.T.I.C. Art.
33 21.07, Secs. 2(n), (o), (p), (q).)

Source Law

(n) A person may not acquire in any manner any ownership interest in an entity licensed as an agent under this subchapter if the person is, or after the acquisition would be, directly or indirectly, in control of the license holder, or otherwise acquire control of or exercise any control over the license holder, unless the person has filed the following information with the department under oath:

(1) a biographical form for each person by whom or on whose behalf the acquisition of control is to be effected;

(2) a statement certifying that no person who is acquiring an ownership interest in or control of the license holder has been the subject of a disciplinary action taken by a financial or insurance regulator of this state, another state, or the United States;

(3) a statement certifying that, immediately on the change of control, the license holder will be able to satisfy the requirements for the issuance of the license to solicit the line or lines of insurance for which it is licensed; and

(4) any additional information that the commissioner may by rule prescribe as necessary or appropriate to the protection of the insurance consumers of this state or as in the public interest.

(o) If a person required to file a statement under Subsection (n) of this section is a partnership, limited partnership, syndicate, or other group, the commissioner may require that the information required by Subdivisions (1)-(4) of that subsection for an individual be provided regarding each partner of the partnership or limited partnership, each member of the syndicate or group, and each person who controls the partner or member. If the partner, member, or person is a corporation or the person required to file the statement under Subsection (n) of this section is a corporation, the commissioner may require that the information required by Subdivisions (1)-(4) of that subsection be provided regarding:

(1) the corporation;

(2) each individual who is an executive officer or director of the corporation; and

(3) each person who is directly or indirectly the beneficial owner of more than 10 percent of the outstanding voting securities of the corporation.

(p) The department may disapprove an acquisition of control if, after notice and opportunity for hearing, the commissioner determines that:

(1) immediately on the change of control the license holder would not be able to satisfy the requirements for the issuance of the license to solicit the line or lines of insurance for which it is presently licensed;

(2) the competence, trustworthiness, experience, and integrity of the persons who would control the operation of the license holder are such that it would not be in the interest of the insurance consumers of this state to permit the acquisition of control; or

(3) the acquisition of control would violate this code or another law of this state, another state, or the United States.

(q) Notwithstanding Subsection (o) of this

1 section, a change in control is considered approved if
2 the department has not proposed to deny the requested
3 change before the 61st day after the date of receipt by
4 the department of all information required by this
5 section.

6 Revisor's Note

7 (1) Section 2(o), V.T.I.C. Article 21.07,
8 refers to a "partnership" or "limited partnership."
9 The revised law omits the references to "limited
10 partnership" because under Section 1A(7), V.T.I.C.
11 Article 21.07, revised as Section 4001.003(7),
12 "partnership" is defined to include "limited
13 partnership."

14 (2) Section 2(q), V.T.I.C. Article 21.07,
15 refers to Section 2(o) of that article. The
16 cross-reference appears to be in error. The correct
17 cross-reference appears to be to Section 2(p) of that
18 article, which is revised in Subsection (c) of this
19 section. The revised law is drafted accordingly.

20 Revised Law

21 Sec. 4001.254. MAINTENANCE OF QUALIFICATIONS. The
22 department shall, in the manner provided by Subchapter C, Chapter
23 4005, revoke, suspend, or refuse to renew the license of a license
24 holder who does not maintain the qualifications necessary to obtain
25 the license. (V.T.I.C. Art. 21.07, Sec. 2(s).)

26 Source Law

27 (s) If a license holder does not maintain the
28 qualifications necessary to obtain the license, the
29 department shall revoke or suspend the license or deny
30 the renewal of the license under Article 21.01-2 of
31 this code.

32 Revised Law

33 Sec. 4001.255. MAINTENANCE OF RECORDS. An agent shall
34 maintain all insurance records, including all records relating to
35 customer complaints, separate from the records of any other
36 business in which the agent may be engaged. (V.T.I.C. Art. 21.07,
37 Sec. 2(t).)

1 Source Law

2 (t) A person licensed under this subchapter
3 shall maintain all insurance records, including all
4 records relating to customer complaints, separate from
5 the records of any other business in which the person
6 may be engaged.

7 [Sections 4001.256-4001.300 reserved for expansion]

8 SUBCHAPTER G. OTHER PERSONS WHO MAY SHARE IN
9 PROFITS OF AGENCY

10 Revised Law

11 Sec. 4001.301. PROFITS AFTER DEATH OF AGENT WHO IS MEMBER OF
12 AGENCY PARTNERSHIP. On the death of an agent who is a member of an
13 agency partnership, the surviving spouse and children, if any, of
14 the deceased partner, or a trust for the surviving spouse and
15 children, may share in the profits of the agency partnership during
16 the lifetime of the surviving spouse or children, as the case may
17 be, as provided by:

18 (1) a written partnership agreement; or

19 (2) in the absence of a written agreement, an
20 agreement by the surviving partner or partners and the surviving
21 spouse, the trustee, and the legal representative of the surviving
22 children. (V.T.I.C. Art. 21.07, Sec. 2A(a).)

23 Source Law

24 Sec. 2A. (a) On the death of a licensed agent
25 who is a member of an agency partnership, the surviving
26 spouse and children, if any, of the deceased partner,
27 or a trust for the surviving spouse and children may
28 share in the profits of such agency partnership during
29 the lifetime of the surviving spouse or children, as
30 the case may be, as provided by a written partnership
31 agreement, or in the absence of any written agreement,
32 as agreed by the surviving partner or partners and the
33 surviving spouse, the trustee, and the legal
34 representative of the surviving child or children.

35 Revised Law

36 Sec. 4001.302. PROFITS AFTER DEATH OF AGENT WHO IS SOLE
37 PROPRIETOR. (a) On the death of an agent who is a sole proprietor,
38 unless otherwise provided by the probated will of the deceased
39 agent, the surviving spouse and children, if any, of the deceased
40 agent, or a trust for the surviving spouse or children, may share in
41 the profits of the agency business of the deceased agent during the

1 lifetime of the surviving spouse and children if the agency
2 business is continued by an agent.

3 (b) The surviving spouse and children or trust is not
4 required to qualify as an agent to share in the profits of the
5 agency but may not perform an act of an agent in connection with the
6 agency business without first being licensed as an agent.
7 (V.T.I.C. Art. 21.07, Sec. 2A(b) (part).)

8 Source Law

9 (b) On the death of a licensed agent, who is a
10 sole proprietorship, unless otherwise provided by the
11 will admitted to probate of that deceased agent, the
12 surviving spouse and children, if any, of the deceased
13 agent, or a trust for the surviving spouse or children,
14 may share in the profits of the continuance of the
15 agency business of the deceased agent, if the agency
16 business is continued by a licensed agent. The
17 surviving spouse, trusts, or children may participate
18 in the profits during the lifetime of the surviving
19 spouse and children. The surviving spouse, trusts, or
20 children are not required to qualify as agents in order
21 to participate in the profits of the agency, but may
22 not do or perform any act of an agent in connection
23 with the continuance of the agency business without
24 first having been licensed as an agent. . . .

25 Revised Law

26 Sec. 4001.303. PROFITS AFTER DEATH OF SHAREHOLDER OF
27 CORPORATE AGENCY. (a) On the death of a shareholder of a corporate
28 licensed agency, the surviving spouse and children, if any, of the
29 deceased shareholder, or a trust for the surviving spouse and
30 children, may share in the profits of the corporate agency during
31 the lifetime of the surviving spouse or children as provided by a
32 contract entered into by each shareholder and the corporation.

33 (b) The surviving spouse and children or trust is not
34 required to qualify as an agent to share in the profits of the
35 corporation but may not perform an act of an agent on behalf of the
36 corporation without qualifying as an agent. (V.T.I.C. Art. 21.07,
37 Sec. 2A(c) (part).)

38 Source Law

39 (c) On the death of a shareholder in a corporate
40 licensed agency, the surviving spouse and children, if
41 any, of the deceased shareholder, or a trust for the
42 surviving spouse and children may share in the profits
43 of the corporate agency during the lifetime of the
44 surviving spouse or children as provided by a contract

1 entered into by and between all of the shareholders and
2 the corporation. A surviving spouse, surviving
3 children, or trusts are not required to individually
4 qualify as an agent in order to participate in the
5 profits, but may not perform any act of an agent on
6 behalf of the corporation without having qualified as
7 an agent. . . .

8 Revised Law

9 Sec. 4001.304. TRANSFER OF INTEREST IN AGENCY BY AGENT WHO
10 IS SOLE PROPRIETOR. (a) An agent who is a sole proprietor may
11 transfer an interest in the agency to the agent's children, or a
12 trust for the agent's children, and may operate that interest for
13 their use and benefit. The children may share in the profits of the
14 agency during their lifetime.

15 (b) The children are not required to qualify as agents to
16 share in the profits of the agency but may not perform an act of an
17 agent in connection with the agency business without first being
18 licensed as agents. (V.T.I.C. Art. 21.07, Sec. 2A(b) (part).)

19 Source Law

20 (b) . . . A licensed agent who is a sole
21 proprietorship may transfer an interest in his agency
22 to his children, or a trust for his children, and may
23 operate that interest for their use and benefit. The
24 children may share in the profits of the agency during
25 their lifetime, and during that time may not be
26 required to qualify as an agent in order to participate
27 in those profits, but may not perform any act of an
28 agent in connection with the agency business without
29 first having been licensed as an agent.

30 Revised Law

31 Sec. 4001.305. TRANSFER OF INTEREST IN AGENCY BY
32 SHAREHOLDER OF CORPORATE AGENCY. (a) A shareholder of a corporate
33 licensed agency may, if provided by a contract entered into by each
34 shareholder and the corporation, transfer an interest in the agency
35 to the shareholder's children or a trust for the shareholder's
36 children. The children or trust may share in the profits of the
37 agency to the extent of that interest during the children's
38 lifetime.

39 (b) The children or trust is not required to qualify as an
40 agent to share in the profits of the corporation but may not perform
41 an act of an agent on behalf of the corporation without qualifying
42 as an agent. (V.T.I.C. Art. 21.07, Sec. 2A(c) (part).)

1 Source Law

2 (c) . . . A shareholder in a corporate
3 licensed agency may, if provided by a contract entered
4 into by and between all of the shareholders and the
5 corporation, transfer an interest in the agency to his
6 children or a trust for his children. The children or
7 trusts may share in the profits of the agency to the
8 extent of that interest during their lifetime. The
9 children or trusts may not be required to qualify as an
10 agent to participate in those profits, but may not
11 perform any act of an agent on behalf of the
12 corporation without having qualified as an agent.

13 CHAPTER 4002. EXAMINATION OF LICENSE APPLICANTS

14 SUBCHAPTER A. GENERAL PROVISIONS

15 Sec. 4002.001. EXAMINATION REQUIRED 1737
16 Sec. 4002.002. EXAMINATION FOR LIMITED LICENSE 1738
17 Sec. 4002.003. EXEMPTIONS FROM EXAMINATION REQUIREMENT . . . 1739
18 Sec. 4002.004. ADVISORY BOARD 1742
19 Sec. 4002.005. EXAMINATION FEE 1743
20 Sec. 4002.006. BILINGUAL EXAMINATION. 1743
21 Sec. 4002.007. EXAMINATION RESULTS 1744

22 [Sections 4002.008-4002.050 reserved for expansion]

23 SUBCHAPTER B. ADMINISTRATION OF EXAMINATION BY TESTING SERVICE

24 Sec. 4002.051. ADMINISTRATION BY TESTING SERVICE
25 AUTHORIZED 1745
26 Sec. 4002.052. AGREEMENT WITH TESTING SERVICE. 1745
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28 [Sections 4002.054-4002.100 reserved for expansion]

29 SUBCHAPTER C. DUTIES OF DEPARTMENT

30 Sec. 4002.101. ADMINISTRATION BY DEPARTMENT. 1746
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33 CHAPTER 4002. EXAMINATION OF LICENSE APPLICANTS

34 SUBCHAPTER A. GENERAL PROVISIONS

35 Revised Law

36 Sec. 4002.001. EXAMINATION REQUIRED. (a) Except as
37 otherwise provided by this code, an applicant for a license to act
38 as an agent in this state must:

- 39 (1) take a personal written examination prescribed by

1 the commissioner; and

2 (2) pass the examination to the satisfaction of the
3 department.

4 (b) The examination must determine the applicant's
5 competence with respect to:

6 (1) the type of insurance contracts for which the
7 applicant seeks a license;

8 (2) the laws of this state regulating the business of
9 insurance; and

10 (3) the ethical obligations and duties of an agent.

11 (V.T.I.C. Art. 21.01-1, Sec. 2(a).)

12 Source Law

13 Sec. 2. (a) Except as otherwise provided by
14 this code, each applicant for a license to act as an
15 insurance agent in this state must submit to a personal
16 written examination that is prescribed by the
17 commissioner and must pass the examination to the
18 satisfaction of the department. The examination shall
19 determine the applicant's competence with respect to:

20 (1) the type of insurance contracts for
21 which the applicant seeks a license;

22 (2) the laws of this state regulating the
23 business of insurance; and

24 (3) the ethical obligations and duties of
25 an insurance agent.

26 Revisor's Note

27 Section 2(a), V.T.I.C. Article 21.01-1, refers to
28 an "insurance agent." The revised law throughout this
29 chapter substitutes "agent" for "insurance agent"
30 because "agent" is the defined term used in this title.
31 See Section 4001.003 of this code.

32 Revised Law

33 Sec. 4002.002. EXAMINATION FOR LIMITED LICENSE. (a) The
34 commissioner shall prescribe a limited written examination for an
35 applicant for a limited agent's license under Chapter 4051 or 4054.

36 (b) The examination must determine the applicant's
37 competence and understanding of:

38 (1) the basic principles of insurance contracts;

39 (2) the basic laws of this state regulating the
40 business of insurance; and

1 (3) the ethical obligations and duties of an agent.
2 (V.T.I.C. Art. 21.01-1, Sec. 2(c).)

3 Source Law

4 (c) The commissioner shall prescribe a limited
5 written licensing examination for applicants for a
6 limited license under Article 21.07-1 or 21.14 of this
7 code. A limited examination shall be administered
8 according to the provisions of this article and shall
9 determine the applicant's competence and understanding
10 of:

11 (1) the basic principles of insurance
12 contracts;

13 (2) the basic laws of this state
14 regulating the business of insurance; and

15 (3) the ethical obligations and duties of
16 an insurance agent.

17 Revisor's Note

18 Section 2(c), V.T.I.C. Article 21.01-1, provides
19 that a limited license examination "shall be
20 administered according to the provisions of this
21 article." The revised law omits the quoted language as
22 unnecessary because the specific provisions of this
23 chapter relating to examinations provide sufficient
24 authority for the administration of a limited license
25 examination. For example, see Sections 4002.051 and
26 4002.101.

27 Revised Law

28 Sec. 4002.003. EXEMPTIONS FROM EXAMINATION REQUIREMENT.

29 (a) The department may not require a person to take an examination
30 under this chapter if the person is:

31 (1) an applicant for the renewal of an unexpired
32 license issued by the department;

33 (2) an applicant whose license issued by the
34 department expired less than one year before the date of the
35 application, if the previous license was not denied, revoked, or
36 suspended by the commissioner;

37 (3) a partnership, corporation, or depository
38 institution;

39 (4) an applicant for a life, accident, and health
40 license who is designated as a chartered life underwriter (CLU);

1 (5) an applicant for a life and health insurance
2 counselor license who is designated as a chartered life underwriter
3 (CLU), chartered financial consultant (ChFC), or certified
4 financial planner (CFP);

5 (6) an applicant for a property and casualty license
6 who is designated as a chartered property casualty underwriter
7 (CPCU);

8 (7) an applicant for a specialty license issued under
9 Chapter 4055;

10 (8) a nonresident individual who is exempt from the
11 examination requirement under Chapter 4056; or

12 (9) an applicant for a general life, accident, and
13 health license who was authorized to solicit or procure insurance
14 on behalf of a fraternal benefit society on September 1, 1999, if
15 the applicant:

16 (A) solicited or procured insurance on behalf of
17 the fraternal benefit society for at least 24 months preceding
18 September 1, 1999; and

19 (B) does not, on or after September 1, 1999,
20 solicit or procure:

21 (i) insurance for any other insurer or a
22 different fraternal benefit society;

23 (ii) an insurance contract from anyone
24 other than a person who is eligible for membership in the fraternal
25 benefit society; or

26 (iii) an interest-sensitive life insurance
27 contract that exceeds \$35,000 of coverage on an individual life,
28 unless the applicant is designated as a "Fraternal Insurance
29 Counselor" at the time the contract is solicited or procured.

30 (b) A license to which the exemption authorized by
31 Subsection (a)(9) applies must be held by the applicant in an
32 individual capacity and is not transferable. (V.T.I.C. Art.
33 21.01-1, Secs. 2(d), (e).)

1 Source Law

2 (d) The department may not require a person to
3 take an examination under this article if the person
4 is:

5 (1) an applicant for the renewal of an
6 unexpired license issued by the department;

7 (2) an applicant whose license issued by
8 the department expired less than one year before the
9 date of the application, if the previous license was
10 not denied, revoked, or suspended by the commissioner;

11 (3) a partnership, corporation, or
12 depository institution;

13 (4) an applicant for a life, accident, and
14 health license who has attained the designation of
15 chartered life underwriter (CLU);

16 (5) an applicant for a life and health
17 insurance counselor license who has attained the
18 designation of chartered life underwriter (CLU),
19 chartered financial consultant (ChFC), or certified
20 financial planner (CFP);

21 (6) an applicant for a property and
22 casualty license who has attained the designation of
23 chartered property and casualty underwriter (CPCU);

24 (7) an applicant for a specialty license
25 issued under Article 21.09 of this code;

26 (8) a nonresident individual who is exempt
27 from the examination requirement under Article 21.11
28 of this code; or

29 (9) an applicant for a general life,
30 accident, and health license who was authorized to
31 solicit or procure insurance on behalf of a fraternal
32 benefit society on September 1, 1999, if the
33 applicant:

34 (A) solicited or procured insurance
35 on behalf of the fraternal benefit society for at least
36 24 months preceding September 1, 1999;

37 (B) does not solicit or procure
38 insurance for any other insurer or a different
39 fraternal benefit society on or after September 1,
40 1999;

41 (C) does not solicit or procure an
42 insurance contract on or after September 1, 1999,
43 except from a person who is eligible for membership in
44 the fraternal benefit society; and

45 (D) does not solicit or procure an
46 interest-sensitive life insurance contract that
47 exceeds \$35,000 of coverage on an individual life on or
48 after September 1, 1999, unless the applicant has
49 obtained the designation of "Fraternal Insurance
50 Counselor" at the time the contract is solicited or
51 procured.

52 (e) A license to which the exemption authorized
53 under Subsection (d)(9) of this section applies must
54 be held by the applicant in an individual capacity and
55 is not transferable.

56 Revisor's Note

57 Section 2(d)(6), V.T.I.C. Article 21.01-1,
58 refers to the designation "chartered property and
59 casualty underwriter (CPCU)." The revised law
60 substitutes "chartered property casualty underwriter
61 (CPCU)" because that is the proper name of the

1 designation.

2 Revised Law

3 Sec. 4002.004. ADVISORY BOARD. (a) The commissioner may
4 appoint one or more advisory boards to make recommendations to the
5 commissioner or the testing service regarding:

6 (1) the scope, type, and conduct of examinations
7 required by this chapter; and

8 (2) the times and locations in this state where the
9 examinations shall be held.

10 (b) The commissioner may appoint to an advisory board any
11 combination of the following:

12 (1) a person who holds a license for which an
13 examination is intended;

14 (2) an employee of an insurer that appoints license
15 holders for which an examination is intended;

16 (3) a person who acts as a general agent or manager;

17 (4) a person who teaches insurance at an accredited
18 college or university in this state; or

19 (5) a resident of this state who is not described by
20 Subdivisions (1)-(4).

21 (c) A member of an advisory board serves without
22 compensation but is entitled to reimbursement for reasonable
23 expenses incurred in attending meetings of the advisory board.

24 (V.T.I.C. Art. 21.01-1, Sec. 1(b).)

25 Source Law

26 (b) The commissioner may appoint advisory
27 boards consisting of any of the following persons:
28 persons holding a license for which the respective
29 examinations are intended, persons who are employed by
30 insurance companies appointing such licensees,
31 persons acting as general agents or managers, persons
32 teaching insurance at an accredited college or
33 university in Texas, persons who are citizens of the
34 State of Texas but who are not of any of the preceding
35 descriptions, or any combination of such persons. The
36 function of such advisory boards will be to make
37 recommendations to the commissioner or the testing
38 service with respect to the scope, type, and conduct of
39 such examinations and the times and places within the
40 state where they shall be held. The members of such
41 advisory boards shall serve without pay but shall be
42 reimbursed for their reasonable expenses in attending

1 meetings of their respective advisory boards.

2 Revisor's Note

3 Section 1(b), V.T.I.C. Article 21.01-1, refers to
4 "citizens of the State of Texas." The revised law
5 substitutes "residents" for "citizens" because, in
6 context, "citizen" and "resident" are synonymous and
7 "resident" is more commonly used.

8 Revised Law

9 Sec. 4002.005. EXAMINATION FEE. (a) The department shall
10 charge each applicant an examination fee in an amount determined by
11 the department as necessary to administer the examination.

12 (b) The examination fee must accompany each application to
13 take the examination.

14 (c) An applicant may receive a refund of the examination fee
15 only if:

16 (1) the applicant fails to take the examination
17 because of an emergency;

18 (2) the applicant notifies the department of the
19 emergency at least 24 hours before the time of the examination; and

20 (3) the department agrees to refund the fee.
21 (V.T.I.C. Art. 21.01-1, Sec. 2(b).)

22 Source Law

23 (b) The department shall charge each applicant
24 an examination fee in an amount determined by the
25 department as necessary for administration of the
26 examination. The fee must accompany each application
27 to take the examination. The fee is nonrefundable
28 other than for failure of the applicant to appear and
29 take the examination after the applicant has given at
30 least 24 hours' notice of an emergency situation to the
31 department and received the department's approval of
32 refund of the fee.

33 Revised Law

34 Sec. 4002.006. BILINGUAL EXAMINATION. An examination
35 administered under this chapter shall be offered in English and
36 Spanish. (V.T.I.C. Art. 21.01-1, Sec. 2(f).)

37 Source Law

38 (f) Each examination administered under this
39 article shall be offered in English and Spanish.

1 Revised Law

2 Sec. 4002.007. EXAMINATION RESULTS. (a) The department
3 shall notify each examinee of the results of a licensing
4 examination administered under this code not later than the 30th
5 day after the date the examination is administered. If an
6 examination is graded or reviewed by a testing service, the
7 department shall notify each examinee of the results of the
8 examination not later than the 14th day after the date the
9 department receives the results from the testing service.

10 (b) The department may require a testing service to notify
11 examinees of the results of an examination.

12 (c) If the notice of the results of an examination graded or
13 reviewed by a testing service will be delayed for longer than 90
14 days after the examination date, the department shall notify the
15 examinee of the reason for the delay before the 90th day.

16 (d) If requested in writing by a person who fails a
17 licensing examination administered under this code, the department
18 shall provide to the person an analysis of the person's performance
19 on the examination. (V.T.I.C. Art. 21.01-1, Secs. 1(d), (e).)

20 Source Law

21 (d) Not later than the 30th day after the date on
22 which a licensing examination is administered under
23 this code, the department shall notify each examinee
24 of the results of the examination. However, if an
25 examination is graded or reviewed by a testing
26 service, the department shall notify each examinee of
27 the results of the examination not later than the 14th
28 day after the date on which the department receives the
29 results from the testing service. If the notice of
30 examination results graded or reviewed by a testing
31 service will be delayed for longer than 90 days after
32 the examination date, the department shall notify the
33 examinee of the reason for the delay before the 90th
34 day. The department may require a testing service to
35 notify examinees of the results of an examination.

36 (e) If requested in writing by a person who
37 fails a licensing examination administered under this
38 code, the department shall furnish the person with an
39 analysis of the person's performance on the
40 examination.

41 [Sections 4002.008-4002.050 reserved for expansion]

1 SUBCHAPTER B. ADMINISTRATION OF EXAMINATION BY TESTING SERVICE

2 Revised Law

3 Sec. 4002.051. ADMINISTRATION BY TESTING SERVICE
4 AUTHORIZED. The commissioner may accept an examination
5 administered by a testing service to satisfy the examination
6 requirements of a person seeking a license as an agent, counselor,
7 or adjuster under this code. (V.T.I.C. Art. 21.01-1, Sec. 1(a)
8 (part).)

9 Source Law

10 Art. 21.01-1
11 Sec. 1. (a) The commissioner may accept
12 examinations administered by a testing service as
13 satisfying the examination requirements of persons
14 seeking license as agents, counselors, or adjusters
15 under this code. . . .

16 Revised Law

17 Sec. 4002.052. AGREEMENT WITH TESTING SERVICE. (a) The
18 commissioner may negotiate an agreement with a testing service to
19 perform examination services, including:

- 20 (1) developing an examination;
21 (2) scheduling an examination;
22 (3) arranging the site for an examination; and
23 (4) administering, grading, reporting, and analyzing
24 an examination.

25 (b) The commissioner may require a testing service to:

- 26 (1) correspond directly with applicants with regard to
27 the administration of examinations;
28 (2) collect fees for administering examinations
29 directly from applicants; and
30 (3) provide for the administration of examinations in
31 specific locations and at specified frequencies.

32 (c) The commissioner shall retain the authority to
33 establish the scope and type of each examination. (V.T.I.C. Art.
34 21.01-1, Sec. 1(a) (part).)

35 Source Law

36 (a) . . . The commissioner may negotiate
37 agreements with such testing services to include

1 performance of examination development, test
2 scheduling, examination site arrangements, and test
3 administration, grading, reporting and analysis. The
4 commissioner may require such testing services to
5 correspond directly with the applicants with regard to
6 the administration of such examinations and that such
7 testing services collect fees for administering such
8 examinations directly from the applicants. The
9 commissioner may stipulate that any agreements with
10 such testing services provide for the administration
11 of examinations in specific locales and at specified
12 frequencies. The commissioner shall retain the
13 authority to establish the scope and type of all
14 examinations. . . .

15 Revised Law

16 Sec. 4002.053. HEARING REQUIRED BEFORE AGREEMENT. Before
17 the department may negotiate and enter into an agreement with a
18 testing service:

19 (1) a hearing must be held in accordance with Chapter
20 2001, Government Code; and

21 (2) the commissioner must adopt any rules or standards
22 that the commissioner considers appropriate to implement the
23 authority granted by this chapter. (V.T.I.C. Art. 21.01-1, Sec.
24 1(a) (part).)

25 Source Law

26 (a) . . . Prior to negotiating and making any
27 agreement with any testing service as authorized
28 hereby, the commissioner shall hold a public hearing
29 in accordance with Chapter 2001, Government Code, and
30 shall adopt such rules and standards as may be deemed
31 appropriate by the commissioner to implement the
32 authority granted in this article.

33 Revisor's Note

34 Section 1(a), V.T.I.C. Article 21.01-1, refers to
35 a "public hearing." The revised law omits "public" as
36 unnecessary. The specific procedures for conducting
37 hearings in this context are established by the law
38 applicable to proceedings before state agencies
39 generally, including Chapter 2001, Government Code.

40 [Sections 4002.054-4002.100 reserved for expansion]

41 SUBCHAPTER C. DUTIES OF DEPARTMENT

42 Revised Law

43 Sec. 4002.101. ADMINISTRATION BY DEPARTMENT. In the
44 absence of an agreement with a testing service, the department

1 shall administer any required examination in accordance with this
2 chapter. (V.T.I.C. Art. 21.01-1, Sec. 1(c) (part).)

3 Source Law

4 (c) In the absence of an agreement with a
5 testing service, the department shall administer any
6 required qualifying examination in accordance with
7 this article. . . .

8 Revised Law

9 Sec. 4002.102. RULES. (a) The commissioner may adopt
10 rules relating to:

11 (1) the scope, type, and conduct of an examination;

12 (2) the time and location in this state at which an
13 examination is conducted; or

14 (3) the designation of textbooks, manuals, and other
15 materials to be studied by an applicant for an examination.

16 (b) The textbooks, manuals, or other materials designated
17 by the commissioner under Subsection (a)(3) may consist of:

18 (1) material available to an applicant by purchase
19 from the publisher; or

20 (2) material prepared at the direction of the
21 commissioner and distributed to an applicant on request and on
22 payment of the reasonable cost of the material. (V.T.I.C. Art.
23 21.01-1, Sec. 1(c) (part).)

24 Source Law

25 (c) . . . The commissioner may adopt rules
26 relating to the scope, type, and conduct of the written
27 examinations and the times and places in this state at
28 which the examinations will be conducted. The
29 commissioner's rules may designate textbooks, manuals,
30 and other materials to be studied by applicants in
31 preparation for examinations conducted under this
32 subsection. Those textbooks, manuals, or other
33 materials may consist of material available to an
34 applicant by purchase from the publisher or of
35 material prepared at the direction of the commissioner
36 and distributed to an applicant on request and on
37 payment of the reasonable cost of the material. . . .

38 Revised Law

39 Sec. 4002.103. CONTENT OF EXAMINATION QUESTIONS. All
40 examination questions must be prepared from the contents of the
41 textbooks, manuals, and other materials designated or prepared by

1 the commissioner under Section 4002.102. (V.T.I.C. Art. 21.01-1,
2 Sec. 1(c) (part).)

3 Source Law

4 (c) . . . All examination questions shall be
5 prepared from the contents of the textbooks, manuals,
6 and other materials designated or prepared by the
7 commissioner under this subsection.

8 CHAPTER 4003. LICENSE EXPIRATION AND RENEWAL

9 Sec. 4003.001. LICENSE EXPIRATION 1748

10 Sec. 4003.002. STAGGERED RENEWAL SYSTEM 1749

11 Sec. 4003.003. NOTICE OF LICENSE EXPIRATION 1749

12 Sec. 4003.004. PROCEDURE FOR RENEWAL OF LICENSE 1750

13 Sec. 4003.005. RENEWAL FEE NONREFUNDABLE 1750

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18 Sec. 4003.009. INTERSTATE MOVE BY AGENT 1752

19 Sec. 4003.010. CHAPTER NOT APPLICABLE TO THIRD-PARTY
20 ADMINISTRATORS 1753

21 CHAPTER 4003. LICENSE EXPIRATION AND RENEWAL

22 Revised Law

23 Sec. 4003.001. LICENSE EXPIRATION. (a) Unless a staggered
24 renewal system is adopted under Section 4003.002, each agent
25 license issued by the department and not suspended or revoked by the
26 commissioner expires on the second anniversary of the date the
27 license is issued.

28 (b) The commissioner by rule may change the two-year
29 expiration period if the commissioner determines that the change is
30 necessary to promote uniformity of license periods of this state
31 with those of other states. (V.T.I.C. Art. 21.01-2, Sec. 1A(a)
32 (part).)

33 Source Law

34 Art. 21.01-2
35 Sec. 1A. (a) Except as provided by a staggered
36 renewal system adopted under Subsection (j) of this
37 section, each agent license issued by the department

1 expires on the second anniversary of the date of
2 issuance unless suspended or revoked by the
3 commissioner. The commissioner by rule may change the
4 two-year expiration period if the commissioner finds
5 that the change is necessary to promote a uniform
6 license period among this state and the other
7 states. . . .

8 Revised Law

9 Sec. 4003.002. STAGGERED RENEWAL SYSTEM. (a) The
10 commissioner by rule may adopt a system under which licenses expire
11 on various dates during a licensing period.

12 (b) For the licensing period in which the license expiration
13 is changed, license fees shall be prorated so that each license
14 holder pays only that portion of the license fee allocable to the
15 period during which the license is valid. On renewal of the license
16 on the new expiration date, the total renewal fee is payable.

17 (c) The commissioner shall adopt a system under which a
18 person who holds more than one license may renew all the licenses
19 held in a single process. (V.T.I.C. Art. 21.01-2, Sec. 1A(j).)

20 Source Law

21 (j) The commissioner by rule may adopt a system
22 under which licenses expire on various dates during a
23 licensing period. For the licensing period in which
24 the license expiration is changed, license fees shall
25 be prorated so that each license holder shall pay only
26 that portion of the license fee that is allocable to
27 the period during which the license is valid. On
28 renewal of the license on the new expiration date, the
29 total license renewal fee is payable. The
30 commissioner shall adopt a system under which a person
31 who holds more than one license may renew all the
32 licenses held in a single process.

33 Revised Law

34 Sec. 4003.003. NOTICE OF LICENSE EXPIRATION. Not later
35 than the 30th day before the date a person's license expires, the
36 department shall send written notice of the impending license
37 expiration to the person at the person's last known mailing address
38 according to the department's records. (V.T.I.C. Art. 21.01-2,
39 Sec. 1A(i).)

40 Source Law

41 (i) At least 30 days before the expiration of a
42 person's license, the department shall send written
43 notice of the impending license expiration to the
44 person at the person's last known mailing address
45 according to the records of the department.

1 Revised Law

2 Sec. 4003.004. PROCEDURE FOR RENEWAL OF LICENSE. (a) A
3 person may renew an unexpired license by:

4 (1) filing a properly completed renewal application
5 with the department in the form prescribed by the department; and

6 (2) paying to the department the required renewal fee
7 in an amount set by the department.

8 (b) A person may not renew a license that has been suspended
9 or revoked. (V.T.I.C. Art. 21.01-2, Secs. 1A(a) (part), (b)
10 (part).)

11 Source Law

12 (a) . . . A person may renew a license that has
13 not expired or has not been suspended or revoked by
14 filing a properly completed renewal application with
15 the department in the form prescribed by the
16 department and paying to the department before the
17 expiration date of the license the required renewal
18 fee. . . .

19 (b) [On the filing of a completed renewal
20 application . . . accompanied by the renewal fee] set
21 by the commissioner[, the original license continues
22 in force]

23 Revised Law

24 Sec. 4003.005. RENEWAL FEE NONREFUNDABLE. A renewal fee
25 paid under this chapter is nonrefundable. (V.T.I.C. Art. 21.01-2,
26 Sec. 1A(a) (part).)

27 Source Law

28 (a) . . . A renewal fee paid under this section
29 is nonrefundable.

30 Revised Law

31 Sec. 4003.006. CONTINUATION OF ORIGINAL LICENSE. The
32 original license of a person who has applied for license renewal in
33 compliance with Section 4003.004 remains in effect from the date
34 the renewal application is filed until the date:

35 (1) the department issues the renewal license; or

36 (2) the commissioner issues an order revoking the
37 license. (V.T.I.C. Art. 21.01-2, Sec. 1A(b) (part).)

38 Source Law

39 (b) On the filing of a completed renewal
40 application not later than the expiration date of the

1 license accompanied by the renewal fee . . . , the
2 original license continues in force until:
3 (1) the department issues the renewal
4 license; or
5 (2) the commissioner issues an order
6 revoking the license.

7 Revised Law

8 Sec. 4003.007. RENEWAL OF EXPIRED LICENSE. (a) A person
9 whose license has been expired for 90 days or less may renew the
10 license by:

11 (1) filing a renewal application with the department
12 in the form prescribed by the department; and

13 (2) paying to the department:

14 (A) the required renewal fee; and

15 (B) an additional fee equal to one-half of the
16 required renewal fee.

17 (b) A person whose license has been expired for more than 90
18 days but less than one year may not renew the license. The person
19 may obtain a new license without taking the applicable examination
20 by:

21 (1) filing a new application with the department; and

22 (2) paying to the department:

23 (A) the license fee; and

24 (B) an additional fee equal to one-half of the
25 license fee.

26 (c) A person whose license has been expired for one year or
27 more may not renew the license. The person may obtain a new license
28 by:

29 (1) submitting to reexamination, if examination is
30 required for original issuance of the license; and

31 (2) complying with the other requirements and
32 procedures for obtaining an original license. (V.T.I.C. Art.
33 21.01-2, Secs. 1A(c), (d), (e).)

34 Source Law

35 (c) If a person's license has been expired for 90
36 days or less, the person may renew the license by
37 filing a renewal application with the department in
38 the form prescribed by the department and paying to the
39 department the required renewal fee and an additional

1 fee that is equal to one-half of the renewal fee for
2 the license.

3 (d) If a person's license has been expired for
4 more than 90 days but less than one year, the person
5 may not renew the license, but is entitled to a new
6 license without taking the applicable examination if
7 the person submits to the department a new
8 application, the license fee, and an additional fee
9 equal to one-half of the license fee.

10 (e) If a person's license has been expired for
11 one year or more, the person may not renew the license.
12 The person may obtain a new license by submitting to
13 reexamination, if examination is required for original
14 issuance of the license, and complying with the
15 requirements and procedures for obtaining an original
16 license.

17 Revised Law

18 Sec. 4003.008. RENEWAL OF EXPIRED LICENSE BY OUT-OF-STATE
19 AGENT. (a) The department may renew without reexamination an
20 expired license of a person who was licensed in this state, moved to
21 another state, and is currently licensed and has been in continual
22 practice in the other state preceding the date of the application.

23 (b) The person must pay to the department a fee equal to the
24 license fee. (V.T.I.C. Art. 21.01-2, Sec. 1A(f).)

25 Source Law

26 (f) The department may renew without
27 reexamination an expired license of a person who was
28 licensed in this state, moved to another state, and is
29 currently licensed and has been in continual practice
30 in the other state preceding the date of the
31 application. The person must pay to the department a
32 fee that is equal to the license fee.

33 Revised Law

34 Sec. 4003.009. INTERSTATE MOVE BY AGENT. (a) Not later
35 than the 30th day after moving from one state to another state, an
36 agent licensed in this state shall file with the department:

37 (1) the agent's new address; and

38 (2) proof of authorization to engage in the business
39 of insurance in the new state of residence.

40 (b) The department may not charge a fee or require a license
41 application under this section. (V.T.I.C. Art. 21.01-2, Secs.
42 1A(g), (h).)

43 Source Law

44 (g) Not later than the 30th day after moving
45 from one state to another state, a nonresident or
46 resident agent licensed in this state shall file with

1 the department:

- 2 (1) the agent's new address; and
- 3 (2) proof of authorization to engage in
- 4 the business of insurance in the new state of
- 5 residence.

6 (h) The department may not charge a fee or
7 require a license application under Subsection (g) of
8 this section.

9 Revisor's Note

10 Section 1A(g), V.T.I.C. Article 21.01-2,
11 provides that all "nonresident or resident" agents
12 must comply with the notification requirements of that
13 section. The revised law omits the quoted language as
14 unnecessary because the phrase includes all agents.

15 Revised Law

16 Sec. 4003.010. CHAPTER NOT APPLICABLE TO THIRD-PARTY
17 ADMINISTRATORS. This chapter does not apply to a certificate of
18 authority issued under Chapter 4151. (V.T.I.C. Art. 21.01-2, Sec.
19 1A(k).)

20 Source Law

21 (k) This section is not applicable to a license
22 issued under Article 21.07-6 of this code.

23 Revisor's Note

24 Section 1A(k), V.T.I.C. Article 21.01-2, refers
25 to a "license" issued under V.T.I.C. Article 21.07-6,
26 revised as Chapter 4151. The revised law substitutes
27 "certificate of authority" for "license" because
28 "certificate of authority" is the term used in Article
29 21.07-6.

30 CHAPTER 4004. CONTINUING EDUCATION

31 SUBCHAPTER A. GENERAL PROVISIONS

32 Sec. 4004.001. DEPARTMENT JURISDICTION EXCLUSIVE. 1754

33 Sec. 4004.002. ADVISORY COUNCIL. 1754

34 [Sections 4004.003-4004.050 reserved for expansion]

35 SUBCHAPTER B. AGENT CONTINUING EDUCATION REQUIREMENTS

36 Sec. 4004.051. GENERAL REQUIREMENTS 1755

37 Sec. 4004.052. EXTENSIONS AND EXEMPTIONS 1756

38 Sec. 4004.053. REQUIREMENTS BASED ON TYPE OF LICENSE HELD . . 1757

1 Sec. 4004.054. ETHICS REQUIREMENT 1758

2 [Sections 4004.055-4004.100 reserved for expansion]

3 SUBCHAPTER C. CONTINUING EDUCATION PROGRAMS

4 Sec. 4004.101. PROGRAM CERTIFICATION. 1758

5 Sec. 4004.102. CERTIFICATION FEE 1758

6 Sec. 4004.103. PROVIDER REGISTRATION; OTHER REQUIREMENTS . . 1759

7 Sec. 4004.104. INDEPENDENT CONTRACTORS 1759

8 CHAPTER 4004. CONTINUING EDUCATION

9 SUBCHAPTER A. GENERAL PROVISIONS

10 Revised Law

11 Sec. 4004.001. DEPARTMENT JURISDICTION EXCLUSIVE. The
12 department has exclusive jurisdiction of all matters relating to
13 the continuing education of agents licensed under this code.
14 (V.T.I.C. Art. 21.01-1, Sec. 3(a).)

15 Source Law

16 Sec. 3. (a) The department has exclusive
17 jurisdiction for all matters relating to the
18 continuing education of insurance agents who are
19 licensed under this code.

20 Revisor's Note

21 Section 3(a), V.T.I.C. Article 21.01-1, refers to
22 "insurance agents." Throughout this chapter the
23 revised law substitutes "agent" for "insurance agent"
24 because "agent" is the defined term used in this title.
25 See Section 4001.003 of this code.

26 Revised Law

27 Sec. 4004.002. ADVISORY COUNCIL. (a) The commissioner
28 may appoint an advisory council to provide the commissioner with
29 information and assistance in the conduct of the continuing
30 education program for agents licensed under this title.

31 (b) If an advisory council is appointed, the council must be
32 composed of nine members, four of whom must be public members.

33 (c) A public member is entitled to reimbursement for the
34 member's travel expenses as provided by Chapter 660, Government
35 Code, and the General Appropriations Act.

1 (d) A public member may not:

2 (1) be an officer, director, or employee of an
3 insurer, insurance agency, agent, broker, adjuster, or other
4 business entity regulated by the department;

5 (2) be a person required to register with the Texas
6 Ethics Commission under Chapter 305, Government Code; or

7 (3) be related to a person described by Subdivision
8 (1) or (2) within the second degree by affinity or consanguinity, as
9 determined under Chapter 573, Government Code. (V.T.I.C. Art.
10 21.01-1, Sec. 3(g).)

11 Source Law

12 (g) The commissioner may appoint an advisory
13 council to provide the commissioner with information
14 and assistance in the conduct of the continuing
15 education program for agents licensed under this
16 subchapter. If an advisory council is appointed, it
17 must be composed of nine members, four of whom must be
18 public members. A public member is entitled to
19 reimbursement for the member's travel expenses as
20 provided by Chapter 660, Government Code, and the
21 General Appropriations Act. A public member may not:

22 (1) be an officer, director, or employee
23 of an insurance company, insurance agency, agent,
24 broker, adjuster, or any other business entity
25 regulated by the department;

26 (2) be a person required to register with
27 the Texas Ethics Commission under Chapter 305,
28 Government Code; or

29 (3) be related to a person described by
30 Subdivision (1) or (2) of this subsection within the
31 second degree by affinity or consanguinity, as
32 determined under Chapter 573, Government Code.

33 [Sections 4004.003-4004.050 reserved for expansion]

34 SUBCHAPTER B. AGENT CONTINUING EDUCATION REQUIREMENTS

35 Revised Law

36 Sec. 4004.051. GENERAL REQUIREMENTS. (a) Except as
37 provided by Section 4004.052 or other law, each individual who
38 holds a license issued by the department shall complete continuing
39 education as provided by this chapter.

40 (b) All required continuing education hours must be
41 completed before the expiration date of the individual's license.

42 (c) At least 50 percent of all required continuing education
43 hours must be completed in a classroom setting or a classroom
44 equivalent setting approved by the department.

1 (d) The department may accept continuing education hours
2 completed in other professions or in association with professional
3 designations in an insurance-related field. (V.T.I.C. Art.
4 21.01-1, Sec. 3(b) (part).)

5 Source Law

6 (b) Except as provided by Subsection (d) of this
7 section, each individual who holds a license issued by
8 the department shall complete continuing education.
9 All required continuing education hours must be
10 completed before the expiration date of the
11 individual's license. . . . At least 50 percent of all
12 required continuing education hours must be completed
13 in a classroom setting or a classroom equivalent
14 setting approved by the department. The department
15 may accept continuing education hours completed in
16 other professions or in association with professional
17 designations in an insurance-related field.

18 Revisor's Note

19 Section 3(b), V.T.I.C. Article 21.01-1, states
20 that "[e]xcept as provided by Subsection (d) of this
21 section" an individual who holds a license issued by
22 the department shall complete certain continuing
23 education requirements. The revised law adds "or
24 other law" because other law, including Section
25 4054.159 of this code, creates additional exemptions
26 to the continuing education requirements for certain
27 agents.

28 Revised Law

29 Sec. 4004.052. EXTENSIONS AND EXEMPTIONS. (a) On the
30 timely written request of an agent, the department may extend the
31 time for the agent to comply with the continuing education
32 requirements of this chapter or may exempt the agent from some or
33 all of the requirements for a licensing period if the department
34 determines that the agent is unable to comply with the requirements
35 because of illness, medical disability, or another extenuating
36 circumstance beyond the control of the agent. The commissioner by
37 rule shall prescribe the criteria for an exemption or extension
38 under this subsection.

39 (b) An individual who has continuously held for at least 20

1 years an agent license issued under this code is exempt from the
2 continuing education requirements of this chapter.

3 (c) The commissioner by rule may provide for other
4 reasonable exemptions from the continuing education requirements
5 of this chapter. (V.T.I.C. Art. 21.01-1, Secs. 3(c), (d).)

6 Source Law

7 (c) On a timely written request of an agent, the
8 department may extend the time for the agent to comply
9 with the continuing education requirements of this
10 section or may exempt the agent from some or all of the
11 requirements for a licensing period if the department
12 finds that the agent is unable to comply with the
13 requirements because of illness, medical disability,
14 or another extenuating circumstance beyond the control
15 of the agent. The commissioner by rule shall prescribe
16 the criteria for an exemption or extension under this
17 subsection.

18 (d) An individual who has continuously held a
19 license issued under this code to operate as an
20 insurance agent for at least 20 years is exempt from
21 the continuing education requirements of this section.
22 The commissioner by rule may provide for other
23 reasonable exemptions.

24 Revised Law

25 Sec. 4004.053. REQUIREMENTS BASED ON TYPE OF LICENSE
26 HELD. (a) An individual who holds a general life, accident, and
27 health license, a life and health insurance counselor license, or a
28 general property and casualty license must complete 15 hours of
29 continuing education annually. If the individual holds more than
30 one license for which continuing education is otherwise required,
31 the individual is not required to complete more than 15 continuing
32 education hours annually.

33 (b) An individual who holds a limited life, accident, and
34 health license or a limited property and casualty license must
35 complete five hours of continuing education annually. (V.T.I.C.
36 Art. 21.01-1, Sec. 3(b) (part).)

37 Source Law

38 (b) . . . An individual who holds a general
39 life, accident, and health license, a life and health
40 insurance counselor license, or a general property and
41 casualty license shall complete 15 hours of continuing
42 education annually. The agent may not be required to
43 complete more than 15 continuing education hours
44 annually as a result of holding more than one license
45 for which continuing education is required. An
46 individual who holds a limited life, accident, and

1 health license or a limited property and casualty
2 license shall complete five hours of continuing
3 education annually. . . .

4 Revised Law

5 Sec. 4004.054. ETHICS REQUIREMENT. Each individual who
6 holds a license issued by the department shall complete two hours of
7 continuing education in ethics during each license renewal period.
8 (V.T.I.C. Art. 21.01-1, Sec. 3(b) (part).)

9 Source Law

10 (b) . . . Each individual who holds a license
11 issued by the department shall complete two hours of
12 continuing education in ethics during each license
13 renewal period. . . .

14 [Sections 4004.055-4004.100 reserved for expansion]

15 SUBCHAPTER C. CONTINUING EDUCATION PROGRAMS

16 Revised Law

17 Sec. 4004.101. PROGRAM CERTIFICATION. (a) The department
18 shall certify continuing education programs for agents. The
19 certification criteria must be designed to ensure that continuing
20 education programs enhance the knowledge, understanding, and
21 professional competence of the license holder.

22 (b) Only a program that satisfies the criteria established
23 by rule by the commissioner may receive certification. (V.T.I.C.
24 Art. 21.01-1, Sec. 3(e) (part).)

25 Source Law

26 (e) The department shall certify continuing
27 education programs for agents. Only a program that
28 satisfies the criteria established by rule by the
29 commissioner may receive certification. The
30 certification criteria shall be designed to ensure
31 that continuing education programs enhance the
32 knowledge, understanding, and professional competence
33 of the license holder. . . .

34 Revised Law

35 Sec. 4004.102. CERTIFICATION FEE. (a) A nonrefundable
36 certification fee, in an amount set by the commissioner as
37 necessary to administer this chapter, must accompany each
38 application for certification of a continuing education program.

39 (b) The commissioner by rule shall establish the
40 certification fee based on a graduated scale according to the

1 number of hours required to complete the program. (V.T.I.C. Art.
2 21.01-1, Sec. 3(e) (part).)

3 Source Law

4 (e) . . . A nonrefundable certification fee,
5 in an amount set by the commissioner as necessary for
6 administering this section, must accompany each
7 application for certification of a continuing
8 education program. The fee shall be established by
9 rule and based on a graduated scale according to the
10 number of hours required to complete the program.

11 Revised Law

12 Sec. 4004.103. PROVIDER REGISTRATION; OTHER REQUIREMENTS.

13 (a) Each continuing education program provider shall register with
14 the department as a course provider.

15 (b) The department shall assess a registration fee for each
16 application for registration as a course provider, set by the
17 commissioner in an amount necessary for the proper administration
18 of this chapter.

19 (c) The commissioner may adopt rules establishing other
20 requirements for continuing education program providers.
21 (V.T.I.C. Art. 21.01-1, Sec. 3(f) (part).)

22 Source Law

23 (f) Each continuing education program provider
24 shall register with the department as a course
25 provider. The department shall assess a registration
26 fee for each application for registration as a
27 provider, set by the commissioner in an amount
28 necessary for the proper administration of this
29 section. The commissioner may adopt rules
30 establishing the requirements for continuing
31 education program providers. . . .

32 Revised Law

33 Sec. 4004.104. INDEPENDENT CONTRACTORS. (a) The
34 department may enter into agreements with independent contractors
35 under which the independent contractor certifies and registers
36 continuing education programs and providers.

37 (b) The department may require the independent contractors
38 to correspond directly with providers with regard to the
39 administration of continuing education programs. The contractors
40 may collect fees from the providers for administration of the
41 courses.

1 (c) Notwithstanding Subsections (a) and (b), the department
2 retains the authority to establish the scope and type of continuing
3 education requirements for each type of license. (V.T.I.C.
4 Art. 21.01-1, Sec. 3(f) (part).)

5 Source Law

6 (f) . . . The department may enter into
7 agreements with independent contractors under which
8 the independent contractor certifies and registers
9 continuing education programs and providers. The
10 department may require those independent contractors
11 to correspond directly with providers with regard to
12 the administration of continuing education programs,
13 and the contractors may collect fees from the
14 providers for administration of the courses. The
15 department retains the authority to establish the
16 scope and type of continuing education requirements
17 for each type of license.

18 CHAPTER 4005. CONDUCT, DISCIPLINARY ACTIONS, AND SANCTIONS

19 SUBCHAPTER A. AUTHORIZED CONDUCT

20 Sec. 4005.001. DEFINITION 1761
21 Sec. 4005.002. AUTHORIZATION TO OBTAIN CERTAIN RECORDS OR
22 PHOTOGRAPHS 1762
23 Sec. 4005.003. FEES 1762

24 [Sections 4005.004-4005.050 reserved for expansion]

25 SUBCHAPTER B. PROHIBITED CONDUCT

26 Sec. 4005.051. APPLICABILITY OF SUBCHAPTER 1763
27 Sec. 4005.052. CERTAIN CONDUCT PROHIBITED AFTER REVOCATION
28 OF LICENSE 1764
29 Sec. 4005.053. CERTAIN PAYMENTS PROHIBITED TO OR FROM PERSON
30 NOT HOLDING LICENSE 1764
31 Sec. 4005.054. RECEIVING ADDITIONAL FEE PROHIBITED. 1766
32 Sec. 4005.055. CERTAIN COVERAGE FOR LOSS BY FIRE
33 PROHIBITED 1766

34 [Sections 4005.056-4005.100 reserved for expansion]

35 SUBCHAPTER C. DISCIPLINARY ACTIONS AND
36 PROCEDURES; ENFORCEMENT

37 Sec. 4005.101. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY
38 ACTION 1767

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2 COMMISSIONER RULES 1769
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10 COMMITTED BEFORE SURRENDER OR FORFEITURE
11 OF LICENSE 1773
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13 Sec. 4005.109. FINES 1774
14 Sec. 4005.110. ENFORCEMENT OF TITLE 1775
15 [Sections 4005.111-4005.150 reserved for expansion]
16 SUBCHAPTER D. CRIMINAL PENALTIES
17 Sec. 4005.151. ACTING AS AGENT AFTER LICENSE SUSPENSION OR
18 REVOCATION; CRIMINAL PENALTY 1776
19 Sec. 4005.152. AGENT ASSISTING OR CONSPIRING WITH PERSON
20 WHOSE LICENSE HAS BEEN SUSPENDED OR
21 REVOKED; CRIMINAL PENALTY 1777
22 Sec. 4005.153. EMBEZZLEMENT OR CONVERSION BY AGENT; CRIMINAL
23 PENALTY 1778

24 CHAPTER 4005. CONDUCT, DISCIPLINARY ACTIONS, AND SANCTIONS

25 SUBCHAPTER A. AUTHORIZED CONDUCT

26 Revised Law

27 Sec. 4005.001. DEFINITION. In this subchapter, "client"
28 means:

- 29 (1) an applicant for insurance coverage; or
- 30 (2) an insured. (V.T.I.C. Art. 21.35A, Sec. (a).)

31 Source Law

32 Art. 21.35A. (a) In this article, "client"
33 means an applicant for insurance coverage or an
34 insured.

1 Revised Law

2 Sec. 4005.002. AUTHORIZATION TO OBTAIN CERTAIN RECORDS OR
3 PHOTOGRAPHS. (a) In connection with a client's application for
4 insurance coverage, the issuance of an insurance policy to a
5 client, or on a client's request, a general property and casualty
6 agent may obtain:

7 (1) the motor vehicle record of a person insured under
8 or to be insured under an insurance policy; or

9 (2) a photograph of property insured under or to be
10 insured under an insurance policy.

11 (b) The agent must provide a copy of the motor vehicle
12 record to the client. (V.T.I.C. Art. 21.35A, Sec. (b) (part).)

13 Source Law

14 (b) [A local recording agent may charge a client
15 a fee to reimburse the agent for costs incurred by the
16 agent] in obtaining a motor vehicle record of a person,
17 or a photograph of property, insured under, or to be
18 insured under, an insurance policy. . . . The agent
19 may obtain the record or photograph in connection with
20 an application for insurance coverage by the client or
21 the issuance of an insurance policy to the client or on
22 the client's request. The agent must provide a copy of
23 the motor vehicle record to the client.

24 Revisor's Note

25 Section (b), V.T.I.C. Article 21.35A, refers to a
26 "local recording agent." Chapter 703, Acts of the 77th
27 Legislature, Regular Session, 2001, in consolidating
28 the types of licenses issued to insurance agents,
29 eliminated the license category of "local recording
30 agent" and provided for a general property and
31 casualty license to be issued to each agent of an
32 insurer authorized to provide property and casualty
33 insurance in this state. Throughout this subchapter,
34 the revised law reflects that change.

35 Revised Law

36 Sec. 4005.003. FEES. (a) A general property and casualty
37 agent may charge a client a fee to reimburse the agent for costs the
38 agent incurred in obtaining a motor vehicle record or photograph of

1 property described under Section 4005.002. The fee may not exceed
2 the actual costs to the agent.

3 (b) For services provided to a client, a general property
4 and casualty agent may charge a reasonable fee, including a fee for:

- 5 (1) special delivery or postal charges;
- 6 (2) printing or reproduction costs;
- 7 (3) electronic mail costs;
- 8 (4) telephone transmission costs; and
- 9 (5) similar costs that the agent incurs on behalf of
10 the client.

11 (c) A general property and casualty agent may charge a
12 client a fee under this section only if, before the agent incurs an
13 expense for the client, the agent:

- 14 (1) notifies the client of the agent's fee; and
- 15 (2) obtains the client's written consent for each fee
16 to be charged. (V.T.I.C. Art. 21.35A, Secs. (b) (part), (c), (d).)

17 Source Law

18 (b) A local recording agent may charge a client
19 a fee to reimburse the agent for costs incurred by the
20 agent in obtaining a motor vehicle record of a person,
21 or a photograph of property, insured under, or to be
22 insured under, an insurance policy. The fee may not
23 exceed the actual costs incurred by the agent. . . .

24 (c) A local recording agent is not prohibited
25 from charging a reasonable fee for services rendered
26 to a client. Those services may include:

- 27 (1) special delivery or postal charges;
- 28 (2) printing and reproduction costs;
- 29 (3) electronic mail costs;
- 30 (4) telephone transmission costs; and
- 31 (5) similar costs that the agent incurs on
32 behalf of the client.

33 (d) An agent may not charge a client a fee under
34 this article unless the agent notifies the client of
35 the agent's fee or reimbursement requirement and
36 obtains the client's written consent for each fee
37 charged before the agent incurs the expense for the
38 client.

39 [Sections 4005.004-4005.050 reserved for expansion]

40 SUBCHAPTER B. PROHIBITED CONDUCT

41 Revised Law

42 Sec. 4005.051. APPLICABILITY OF SUBCHAPTER. This
43 subchapter does not apply to a person who holds a license or
44 certificate of authority issued under Title 11. (V.T.I.C. Art.

1 21.01-2, Sec. 2A(i).)

2 Source Law

3 (i) This section does not apply to a person who
4 is licensed under or holds a certificate of authority
5 issued under Chapter 9 of this code.

6 Revised Law

7 Sec. 4005.052. CERTAIN CONDUCT PROHIBITED AFTER REVOCATION
8 OF LICENSE. A person whose insurance license has been revoked in
9 this state or any other state may not:

10 (1) solicit or otherwise engage in business under
11 Chapter 885 unless the department determines it to be in the public
12 interest, for good cause shown, to permit the person to act in that
13 capacity; or

14 (2) act as an officer, director, member, manager, or
15 partner, or as a shareholder with a controlling interest, of an
16 entity holding a license issued under this title unless the
17 department determines it to be in the public interest, for good
18 cause shown, to permit the person to act in that capacity.
19 (V.T.I.C. Art. 21.01-2, Secs. 2A(e), (f).)

20 Source Law

21 (e) A person who has had an insurance license
22 revoked in this state or any other state may not
23 solicit or otherwise transact business under Chapter
24 10 of this code unless it is determined by the
25 department to be in the public interest, for good cause
26 shown, to allow the person to act in that capacity.

27 (f) A person who has had an insurance license
28 revoked in this state or any other state may not act as
29 an officer, director, member, manager, or partner, or
30 as a shareholder with a controlling interest, of an
31 entity licensed under this subchapter unless it is
32 determined by the department to be in the public
33 interest, for good cause shown, to allow the person to
34 act in that capacity.

35 Revised Law

36 Sec. 4005.053. CERTAIN PAYMENTS PROHIBITED TO OR FROM
37 PERSON NOT HOLDING LICENSE. (a) An insurer or agent engaged in the
38 business of insurance in this state may not pay to any person,
39 directly or indirectly, and may not accept from any person a
40 commission or other valuable consideration for a service performed
41 by that person as an agent in this state unless the person holds a

1 license to act as an agent in this state.

2 (b) Subsection (a) does not prevent the payment of a renewal
3 or other deferred commission to a person or the acceptance of a
4 renewal or other deferred compensation by a person solely because
5 the person no longer holds a license to act as an agent.

6 (c) An agent may not pay, permit, or give or offer to pay,
7 permit, or give, directly or indirectly, to any person who does not
8 hold a license as an agent:

9 (1) a rebate of premiums payable, a commission,
10 employment, a contract for service, or any other valuable
11 consideration or inducement that is not specified in the insurance
12 policy or contract for or on account of the solicitation or
13 negotiation of an insurance contract; or

14 (2) a fee or other valuable consideration for
15 referring a customer who seeks to purchase an insurance product or
16 seeks an opinion on or advice regarding an insurance product, based
17 on that customer's purchase of insurance. (V.T.I.C. Art. 21.01-2,
18 Secs. 2A(b), (c), (h).)

19 Source Law

20 (b) An insurer or licensed insurance agent
21 engaged in the business of insurance in this state may
22 not pay, directly or indirectly, and may not accept,
23 any commission or other valuable consideration to or
24 from any person for services performed by that person
25 as an insurance agent in this state unless the person
26 holds a license to act as an insurance agent as
27 required by the laws of this state. This subsection
28 does not prevent the payment or receipt of renewal or
29 other deferred commissions to or by any person solely
30 because the person has ceased to hold a license to act
31 as an insurance agent.

32 (c) An insurance agent licensed under this code
33 may not pay, allow, or give, or offer to pay, allow, or
34 give, directly or indirectly, to any person who is not
35 a licensed insurance agent, any rebate of premiums
36 payable, commission, paid employment, or contract for
37 service, or any other valuable consideration or
38 inducement, that is not specified in the policy or
39 contract of insurance for or on account of the
40 solicitation or negotiation of contracts of insurance.

41 (h) An insurance agent licensed under this code
42 may not pay, allow, or give, or offer to pay, allow, or
43 give, directly or indirectly, to a person who is not a
44 licensed insurance agent, a fee or other valuable
45 consideration for the referral of a customer who seeks
46 to purchase, or seeks an opinion on or advice regarding
47 an insurance product, based on the purchase of

1 insurance by that customer.

2 Revisor's Note

3 Sections 2A(b), (c), and (h), V.T.I.C. Article
4 21.01-2, refer to a "licensed insurance agent" or
5 "insurance agent licensed under this code."
6 Throughout this chapter, the revised law omits as
7 unnecessary the references to "licensed" or "licensed
8 under this code" in connection with an agent because
9 under Section 4001.101 all agents are required to hold
10 licenses under this code. In addition, throughout
11 this chapter, the revised law substitutes "agent" for
12 "insurance agent" because "agent" is the defined term
13 used in this title. See Section 4001.003 of this code.

14 Revised Law

15 Sec. 4005.054. RECEIVING ADDITIONAL FEE PROHIBITED. A
16 person who holds a license under this code and receives a commission
17 or other consideration for services as an agent may not receive an
18 additional fee for those services provided to the same client
19 except for a fee described by Section 550.001 or 4005.003.
20 (V.T.I.C. Art. 21.01-2, Sec. 2A(a).)

21 Source Law

22 Sec. 2A. (a) A person licensed under this code
23 who receives a commission or other consideration for
24 services as an insurance agent may not receive an
25 additional fee for those services provided to the same
26 client except for a fee described by Article 21.35A or
27 21.35B of this code.

28 Revised Law

29 Sec. 4005.055. CERTAIN COVERAGE FOR LOSS BY FIRE
30 PROHIBITED. A property and casualty agent may not knowingly grant,
31 write, or permit a greater amount of insurance against loss by fire
32 than the reasonable value of the insured subject. (V.T.I.C. Art.
33 21.01-2, Sec. 2A(g).)

34 Source Law

35 (g) A property and casualty agent may not
36 knowingly grant, write, or permit a greater amount of
37 insurance against loss by fire than the reasonable
38 value of the subject of the insurance.

1 [Sections 4005.056-4005.100 reserved for expansion]

2 SUBCHAPTER C. DISCIPLINARY ACTIONS AND

3 PROCEDURES; ENFORCEMENT

4 Revised Law

5 Sec. 4005.101. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY
6 ACTION. (a) This section does not apply to a person who holds a
7 license or certificate of authority issued under Title 11.

8 (b) The department may deny a license application or
9 discipline a license holder under this subchapter if the department
10 determines that the applicant or license holder, individually or
11 through an officer, director, or shareholder:

12 (1) has wilfully violated an insurance law of this
13 state;

14 (2) has intentionally made a material misstatement in
15 the license application;

16 (3) has obtained or attempted to obtain a license by
17 fraud or misrepresentation;

18 (4) has misappropriated, converted to the applicant's
19 or license holder's own use, or illegally withheld money belonging
20 to:

21 (A) an insurer;

22 (B) a health maintenance organization; or

23 (C) an insured, enrollee, or beneficiary;

24 (5) has engaged in fraudulent or dishonest acts or
25 practices;

26 (6) has materially misrepresented the terms and
27 conditions of an insurance policy or contract, including a contract
28 relating to membership in a health maintenance organization;

29 (7) has made or issued, or caused to be made or issued,
30 a statement misrepresenting or making incomplete comparisons
31 regarding the terms or conditions of an insurance or annuity
32 contract legally issued by an insurer or a membership issued by a
33 health maintenance organization to induce the owner of the contract
34 or membership to forfeit or surrender the contract or membership or

1 allow it to lapse for the purpose of replacing the contract or
2 membership with another;

3 (8) has been convicted of a felony;

4 (9) has offered or given a rebate of an insurance
5 premium or commission to an insured or enrollee;

6 (10) is not actively engaged in soliciting or writing
7 insurance for the public generally as required by Section
8 4001.104(a); or

9 (11) has obtained or attempted to obtain a license,
10 not for the purpose of holding the applicant or license holder out
11 to the general public as an agent, but primarily for the purpose of
12 soliciting, negotiating, or procuring an insurance or annuity
13 contract or membership covering:

14 (A) the applicant or license holder;

15 (B) a member of the applicant's or license
16 holder's family; or

17 (C) a business associate of the applicant or
18 license holder. (V.T.I.C. Art. 21.01-2, Secs. 3A(c), (h).)

19 Source Law

20 (c) The department may discipline a license
21 holder or deny a license application under this
22 article if the department determines that the
23 applicant or license holder, individually or through
24 any officer, director, or shareholder:

25 (1) has wilfully violated any provision of
26 the insurance laws of this state;

27 (2) has intentionally made a material
28 misstatement in the license application;

29 (3) has obtained, or attempted to obtain,
30 a license by fraud or misrepresentation;

31 (4) has misappropriated, converted to the
32 applicant's or license holder's own use, or illegally
33 withheld money belonging to:

34 (A) an insurer;

35 (B) a health maintenance
36 organization; or

37 (C) an insured, enrollee, or
38 beneficiary;

39 (5) has engaged in fraudulent or dishonest
40 acts or practices;

41 (6) has materially misrepresented the
42 terms and conditions of an insurance policy or
43 contract, including a contract relating to membership
44 in a health maintenance organization;

45 (7) has made or issued, or caused to be
46 made or issued, any statement misrepresenting or
47 making incomplete comparisons regarding the terms or
48 conditions of an insurance or annuity contract legally

1 issued by an insurer or a membership issued by a health
2 maintenance organization to induce the owner of the
3 contract or membership to forfeit or surrender the
4 contract or membership or allow it to lapse for the
5 purpose of replacing the contract or membership with
6 another;

7 (8) is convicted of a felony;

8 (9) has offered or given a rebate of an
9 insurance premium or commission to an insured or
10 enrollee;

11 (10) is not actively engaged in the
12 soliciting or writing of insurance for the public
13 generally as required by Section 2(c), Article 21.07,
14 of this code; or

15 (11) has obtained or attempted to obtain a
16 license, not for the purpose of holding the license
17 holder or applicant out to the general public as an
18 agent, but primarily for the purpose of soliciting,
19 negotiating, or procuring insurance or annuity
20 contracts or memberships covering:

21 (A) the applicant or license holder;

22 (B) a member of the applicant's or
23 license holder's family; or

24 (C) a business associate of the
25 applicant or license holder.

26 (h) Subsections (c)-(f) of this section do not
27 apply to a person who is licensed under or holds a
28 certificate of authority issued under Chapter 9 of
29 this code.

30 Revised Law

31 Sec. 4005.102. REMEDIES FOR VIOLATION OF INSURANCE LAWS OR
32 COMMISSIONER RULES. In addition to any other remedy available
33 under Chapter 82, for a violation of this code, another insurance
34 law of this state, or a rule of the commissioner, the department
35 may:

36 (1) deny an application for an original license;

37 (2) suspend, revoke, or deny renewal of a license;

38 (3) place on probation a person whose license has been
39 suspended;

40 (4) assess an administrative penalty; or

41 (5) reprimand a license holder. (V.T.I.C. Art.
42 21.01-2, Sec. 3A(a) (part).)

43 Source Law

44 Sec. 3A. (a) In addition to any other remedy
45 available under Chapter 82 of this code, the
46 department may refuse to issue an original license,
47 revoke, suspend, or refuse to renew a license, place on
48 probation a person whose license has been suspended,
49 assess an administrative penalty, or reprimand a
50 license holder for a violation of this code, another
51 insurance law of this state, or a rule of the
52 commissioner. . . .

1 Revised Law

2 Sec. 4005.103. PROBATED LICENSE SUSPENSION. If a license
3 suspension is probated, the commissioner may require the license
4 holder to:

5 (1) report regularly to the department on any matter
6 that is the basis of the probation;

7 (2) limit the license holder's practice to the areas
8 prescribed by the department; or

9 (3) continue or review professional education until
10 the license holder attains a degree of skill satisfactory to the
11 commissioner in each area that is the basis of the probation.

12 (V.T.I.C. Art. 21.01-2, Sec. 3A(a) (part).)

13 Source Law

14 (a) . . . If a license suspension is probated,
15 the commissioner may require the person to:

16 (1) report regularly to the department on
17 matters that are the basis of the probation;

18 (2) limit the person's practice to the
19 areas prescribed by the department; or

20 (3) continue or review professional
21 education until the person attains a degree of skill
22 satisfactory to the commissioner in those areas that
23 are the basis of the probation.

24 Revised Law

25 Sec. 4005.104. HEARING. (a) If the department proposes
26 to deny an application for an original license or to suspend,
27 revoke, or deny renewal of a license, the applicant or license
28 holder is entitled to a hearing conducted by the State Office of
29 Administrative Hearings as provided by Chapter 40.

30 (b) Notice of the hearing shall be provided to:

31 (1) the applicant or license holder; and

32 (2) any insurer indicated on the application as
33 desiring that the license be issued. (V.T.I.C. Art. 21.01-2, Sec.
34 3A(b).)

35 Source Law

36 (b) If the department proposes to refuse to
37 issue an original license, or to suspend, revoke, or
38 refuse to renew a license, the person affected is
39 entitled to a hearing conducted by the State Office of
40 Administrative Hearings in accordance with Chapter 40
41 of this code. Notice of the hearing shall be provided

1 to the person and to any insurance carrier appearing on
2 the application as desiring that the license be
3 issued.

4 Revised Law

5 Sec. 4005.105. APPLICATION FOR LICENSE AFTER DENIAL OF
6 APPLICATION OR REVOCATION OF LICENSE. (a) This section does not
7 apply to a person who holds a license or certificate of authority
8 issued under Title 11.

9 (b) An individual whose license application has been denied
10 or whose license has been revoked under this subchapter may not
11 apply for an agent license before the fifth anniversary of:

12 (1) the effective date of the denial or revocation; or

13 (2) the date of a final court order affirming the
14 denial or revocation if judicial review was sought.

15 (c) A license application filed after the time required by
16 Subsection (b) may be denied by the commissioner if the applicant
17 fails to show good cause why the denial or revocation should not be
18 a bar to the issuance of a new license.

19 (d) Subsection (c) does not apply to an applicant whose
20 license application was denied for failure by the applicant to:

21 (1) pass a required written examination; or

22 (2) submit a properly completed license application.

23 (V.T.I.C. Art. 21.01-2, Secs. 3A(d), (e), (h).)

24 Source Law

25 (d) An individual whose license application is
26 denied or whose license has been revoked under this
27 article may not apply for any license as an insurance
28 agent before the fifth anniversary of:

29 (1) the effective date of the denial or
30 revocation; or

31 (2) if the applicant or license holder
32 seeks judicial review of the department's action, the
33 date of the final court order or decree affirming that
34 action.

35 (e) The commissioner may deny a timely
36 application filed under Subsection (d) of this section
37 if the applicant does not show good cause why the
38 denial or revocation of the previous license
39 application or license should not be considered a bar
40 to the issuance of a new license. This subsection does
41 not apply to an applicant whose license application
42 was denied for failure to:

43 (1) pass a required written examination;

44 or

45 (2) submit a properly completed license
46 application.

1 (h) Subsections (c)-(f) of this section do not
2 apply to a person who is licensed under or holds a
3 certificate of authority issued under Chapter 9 of
4 this code.

5 Revisor's Note

6 Section 3A(d)(2), V.T.I.C. Article 21.01-2,
7 refers to a "court order or decree." The revised law
8 omits the reference to "decree" because, in context,
9 "court order" and "decree" have the same meaning and
10 the former term is more commonly used.

11 Revised Law

12 Sec. 4005.106. APPLICATION FOR LICENSE AFTER CERTAIN
13 DETERMINATIONS. (a) In addition to any other penalty imposed
14 under this code, a person who the department determines has engaged
15 in conduct described by this section may not obtain a license as an
16 agent before the fifth anniversary of the date of the
17 determination.

18 (b) This section applies to a person who:

19 (1) acts as an agent without holding a license under
20 this code;

21 (2) solicits an insurance contract or acts as an agent
22 without having been appointed or designated by an authorized
23 insurer, association, or organization to do so as provided by this
24 code;

25 (3) solicits an insurance contract or acts as an agent
26 for a person, including an insurer, association, or organization,
27 who is not authorized to engage in the business of insurance in this
28 state without holding a surplus lines agent license issued under
29 Chapter 981; or

30 (4) as an officer or representative of an insurer,
31 knowingly contracts with or appoints as an agent a person who does
32 not hold a valid license. (V.T.I.C. Art. 21.01-2, Sec. 2A(d).)

33 Source Law

34 (d) In addition to any other penalty imposed
35 under this code, a person who is determined by the
36 department to have committed conduct described by this
37 subsection is barred from receiving a license as an

1 insurance agent before the fifth anniversary of the
2 date of the determination. This subsection applies to
3 a person who:

4 (1) acts as an insurance agent without
5 holding a license under this code;

6 (2) solicits a contract of insurance or
7 acts as an insurance agent without having been
8 appointed or designated by an authorized insurance
9 company, association, or organization to do so as
10 provided by this code;

11 (3) solicits any contract of insurance or
12 acts as an agent for a person, including an insurance
13 company, association, or organization, not authorized
14 to engage in the business of insurance in this state
15 without holding a license issued under Article 1.14-2
16 of this code; or

17 (4) as an officer or representative of an
18 insurance company, knowingly contracts with or
19 appoints as an agent a person who does not hold a valid
20 and outstanding license.

21 Revisor's Note

22 Section 2A(d), V.T.I.C. Article 21.01-2, refers
23 to a "valid and outstanding license." The revised law
24 omits "outstanding" because, in this context, the
25 meaning of "outstanding" is included in the meaning of
26 "valid."

27 Revised Law

28 Sec. 4005.107. DISCIPLINARY PROCEEDING FOR CONDUCT
29 COMMITTED BEFORE SURRENDER OR FORFEITURE OF LICENSE. (a) The
30 department may institute a disciplinary proceeding against a former
31 license holder for conduct committed before the effective date of a
32 voluntary surrender or automatic forfeiture of the license.

33 (b) In a proceeding under this section, the fact that the
34 license holder has surrendered or forfeited the license does not
35 affect the former license holder's culpability for the conduct that
36 is the subject of the proceeding. (V.T.I.C. Art. 21.01-2, Sec.
37 3A(g).)

38 Source Law

39 (g) The department may institute a disciplinary
40 proceeding against a license holder for conduct that
41 the license holder committed before the effective date
42 of a voluntary surrender or automatic forfeiture of
43 the license. In the proceeding, the fact that the
44 license holder has surrendered or forfeited the
45 license does not affect the license holder's
46 culpability for that conduct.

1 Revised Law

2 Sec. 4005.108. DISABILITY PROBATION. (a) This section
3 does not apply to a person who holds a license or certificate of
4 authority issued under Title 11.

5 (b) Instead of or in addition to taking disciplinary action
6 under Section 4005.102, 4005.103, 4005.105(c), or 4005.107, the
7 department may order that a license holder who is disabled be placed
8 on disability probation under the terms specified under Chapter
9 4006 and department rules. (V.T.I.C. Art. 21.01-2, Secs. 3A(f),
10 (h).)

11 Source Law

12 (f) Instead of or in addition to taking
13 disciplinary action under this section, the department
14 may order that a license holder who is currently
15 afflicted with a disability be placed on disability
16 probation under the terms and conditions specified
17 under Article 21.15-6 of this code and department
18 rules.

19 (h) Subsections (c)-(f) of this section do not
20 apply to a person who is licensed under or holds a
21 certificate of authority issued under Chapter 9 of
22 this code.

23 Revised Law

24 Sec. 4005.109. FINES. (a) To expedite the department's
25 processing of certain violations of this code, the commissioner by
26 rule may establish fines for certain violations.

27 (b) A violation for which a fine may be assessed under this
28 section includes a failure to:

29 (1) obtain the total number of continuing education
30 hours before the renewal date of a license;

31 (2) timely report a change of address to the
32 department; or

33 (3) notify the department of an administrative action
34 against the agent by a financial or insurance regulator of another
35 state or of the federal government.

36 (c) This section does not limit the department's authority
37 to take any other disciplinary action against a license holder as
38 otherwise provided by this code.

1 (d) The dispute of an assessment of a fine under this
2 section is a contested case subject to Chapter 2001, Government
3 Code. (V.T.I.C. Art. 21.01-2, Sec. 5A.)

4 Source Law

5 Sec. 5A. (a) To expedite the department's
6 processing of certain violations of this code, the
7 commissioner may establish by rule monetary fines for
8 certain violations. Violations for which the fines
9 may be assessed include a failure to:

10 (1) obtain the total number of continuing
11 education hours before the renewal date of the
12 license;

13 (2) timely report a change of address to
14 the department; or

15 (3) notify the department of an
16 administrative action taken against the agent by
17 another state or federal financial or insurance
18 regulator.

19 (b) This section does not limit the department's
20 authority to take any other disciplinary action
21 against a license holder as provided under another
22 provision of this code.

23 (c) If a person disputes the assessment of a
24 fine under this section, the matter is a contested case
25 subject to Chapter 2001, Government Code.

26 Revisor's Note

27 Section 5A(a), V.T.I.C. Article 21.01-2, refers
28 to assessing a "monetary" fine. The revised law omits
29 as unnecessary the reference to "monetary" because the
30 term does not add to the clear meaning of the law.

31 Revised Law

32 Sec. 4005.110. ENFORCEMENT OF TITLE. The attorney
33 general, a district or county attorney, or the department acting
34 through the commissioner may bring a proceeding for an injunction
35 or bring any other proceeding to enforce this title and to enjoin
36 any person, firm, corporation, or depository institution from
37 engaging in or attempting to engage in the business of insurance in
38 violation of this code or any other insurance law of this state.
39 (V.T.I.C. Art. 21.01-2, Sec. 6A (part).)

40 Source Law

41 Sec. 6A. The attorney general, a district or
42 county attorney, or the department acting through the
43 commissioner may institute an injunction proceeding or
44 any other proceeding to enforce this subchapter and to
45 enjoin any person, firm, corporation, or depository
46 institution from engaging or attempting to engage in
47 the business of insurance in violation of this code or

1 any other insurance law of this state. . . .

2 Revisor's Note

3 Section 6A, V.T.I.C. Article 21.01-2, provides
4 that the "provisions of this section are cumulative of
5 the other penalties or remedies provided by this
6 article." The revised law omits that provision as
7 unnecessary because an accepted principle of statutory
8 construction requires a statute to be given cumulative
9 effect with other statutes unless it provides
10 otherwise or unless the statutes are in conflict. The
11 general provision applies to the revision. The
12 omitted law reads:

13 Sec. 6A. . . . The provisions of
14 this section are cumulative of the other
15 penalties or remedies provided by this
16 article.

17 [Sections 4005.111-4005.150 reserved for expansion]

18 SUBCHAPTER D. CRIMINAL PENALTIES

19 Revised Law

20 Sec. 4005.151. ACTING AS AGENT AFTER LICENSE SUSPENSION OR
21 REVOCATION; CRIMINAL PENALTY. (a) A person commits an offense if
22 the person acts as an agent after the person's agent license has
23 been suspended or revoked.

24 (b) An offense under this section is a felony punishable by:

25 (1) a fine not to exceed \$5,000;

26 (2) imprisonment for a term of not more than two years;

27 or

28 (3) both fine and imprisonment under this subsection.

29 (V.T.I.C. Art. 21.15-1, Sec. 1.)

30 Source Law

31 Art. 21.15-1

32 Sec. 1. It shall be unlawful for any person,
33 whose license as an insurance agent or insurance
34 solicitor has been suspended or revoked, to do or
35 perform any of the acts of an insurance agent or
36 insurance solicitor. Any person violating this
37 section shall be guilty of a felony and upon conviction
38 shall be punished by a fine of not more than Five
39 Thousand Dollars (\$5,000) or be imprisoned for not
40 more than two years, or be punished by both fine and
41 imprisonment.

1 Revisor's Note

2 Section 1, V.T.I.C. Article 21.15-1, refers to a
3 person whose license as "an insurance agent or
4 insurance solicitor" has been suspended or revoked.
5 Throughout this subchapter, the revised law omits the
6 reference to "solicitor" because that term, as it
7 relates to a particular type of person engaged in the
8 business of insurance, was eliminated by Chapter 703,
9 Acts of the 77th Legislature, Regular Session, 2001,
10 and a person who performs the duties formerly
11 performed by a solicitor is now regulated as an
12 "agent."

13 Revised Law

14 Sec. 4005.152. AGENT ASSISTING OR CONSPIRING WITH PERSON
15 WHOSE LICENSE HAS BEEN SUSPENDED OR REVOKED; CRIMINAL
16 PENALTY. (a) A person commits an offense if the person is an
17 agent who holds a license under this code and the person assists or
18 conspires with a person whose license as an agent has been suspended
19 or revoked to act as an agent.

20 (b) An offense under this section is a misdemeanor
21 punishable by:

22 (1) a fine not to exceed \$1,000;

23 (2) confinement in jail for a term of not more than six
24 months; or

25 (3) both fine and confinement in jail under this
26 subsection. (V.T.I.C. Art. 21.15-1, Sec. 2.)

27 Source Law

28 Sec. 2. It shall be unlawful for any insurance
29 agent or insurance solicitor with a license to engage
30 in the business of soliciting and writing insurance to
31 assist, aid or conspire with a person, whose license as
32 an insurance agent or insurance solicitor has been
33 suspended or revoked, to engage in any acts as an
34 insurance agent or insurance solicitor. Any person
35 violating this section shall be guilty of a
36 misdemeanor and upon conviction shall be punished by a
37 fine of not more than One Thousand Dollars (\$1,000) or
38 confined in jail for not more than six months, or be
39 punished by both fine and confinement in jail.

1 Revisor's Note

2 (1) Section 2, V.T.I.C. Article 21.15-1, refers
3 to an agent "with a license to engage in the business
4 of soliciting and writing insurance." The revised law
5 substitutes "who holds a license under this code" for
6 the quoted language for consistency with other
7 provisions of this chapter.

8 (2) Section 2, V.T.I.C. Article 21.15-1,
9 provides that it is unlawful for an agent to "assist,
10 aid or conspire" with a person whose license as an
11 agent or insurance solicitor has been suspended or
12 revoked. The revised law omits the reference to "aid"
13 because "aid" is included within the meaning of
14 "assist."

15 Revised Law

16 Sec. 4005.153. EMBEZZLEMENT OR CONVERSION BY AGENT;
17 CRIMINAL PENALTY. (a) A person commits an offense if the person,
18 as an agent for an insurer lawfully engaged in the business of
19 insurance in this state, collects premiums or otherwise receives
20 money or a substitute for money, and the person:

21 (1) embezzles, fraudulently converts, or appropriates
22 to the person's own use the money or substitute for money; or

23 (2) with intent to embezzle and contrary to the
24 instructions of or without the consent of the insurer, takes,
25 secretes, or otherwise disposes of or fraudulently withholds,
26 appropriates, lends, invests, or otherwise uses or applies, any
27 money or substitute for money received by the person in the person's
28 capacity as agent or broker.

29 (b) A person who commits an offense under this section shall
30 be punished as if the person had stolen the money or substitute for
31 money. (V.T.I.C. Art. 21.15-5.)

32 Source Law

33 Art. 21.15-5. Any insurance agent or solicitor
34 who collects premiums for an insurance company
35 lawfully doing business in this State and who

1 embezzles or fraudulently converts or appropriates to
2 his own use, or with intent to embezzle takes,
3 secretes, or otherwise disposes of or fraudulently
4 withholds, appropriates, lends, invests or otherwise
5 uses or applies any money or substitutes for money
6 received by him as such agent or broker, contrary to
7 the instructions or without the consent of the company
8 for or on account of which the same was received by
9 him, shall be punished as if he had stolen the same.

10 Revisor's Note
11 (End of Chapter)

12 Section 4A, V.T.I.C. Article 21.01-2, authorizes
13 a license holder or license applicant to appeal in
14 certain cases as provided by Chapter 36 of this code.
15 The revised law omits that provision as redundant
16 because a disciplinary action or denial of an
17 application under Article 21.01-2 is already subject
18 to appeal in the manner provided by Chapter 36, and an
19 additional statement to that effect in this chapter is
20 unnecessary. The omitted law reads:

21 Sec. 4A. A license applicant or
22 license holder may appeal as provided by
23 Chapter 36 of this code if:

24 (1) the commissioner:

25 (A) refuses an application
26 for a license as provided by this article;
27 or

28 (B) suspends, revokes, or
29 refuses to renew a license at a hearing as
30 provided by this article; and

31 (2) the applicant or license
32 holder is dissatisfied with the action of
33 the commissioner.

34 CHAPTER 4006. DISABILITY PROBATION OF AGENTS

35 SUBCHAPTER A. GENERAL PROVISIONS

36 Sec. 4006.001. DEFINITION 1780

37 Sec. 4006.002. RULES 1780

38 [Sections 4006.003-4006.050 reserved for expansion]

39 SUBCHAPTER B. POWERS AND DUTIES OF DEPARTMENT

40 Sec. 4006.051. DISABILITY PROBATION ORDER 1780

41 Sec. 4006.052. RESTITUTION 1781

42 Sec. 4006.053. DURATION OF PROBATION 1782

43 Sec. 4006.054. PROBATION CONDITIONS 1782

44 Sec. 4006.055. SUPERVISION DURING PROBATION. 1783

45 Sec. 4006.056. EFFECT OF NONCOMPLIANCE. 1784

1 CHAPTER 4006. DISABILITY PROBATION OF AGENTS

2 SUBCHAPTER A. GENERAL PROVISIONS

3 Revised Law

4 Sec. 4006.001. DEFINITION. In this chapter, "disability"
5 means any physical, mental, or emotional condition that results in
6 an agent's inability to carry out the agent's professional
7 responsibilities to insureds, the profession, or the public.
8 (V.T.I.C. Art. 21.15-6, Sec. (a) (part).)

9 Source Law

10 Art. 21.15-6. (a) . . . For the purposes of
11 this article, "disability" means any physical, mental,
12 or emotional condition that results in an agent's
13 inability to carry out the agent's professional
14 responsibilities to insureds, the profession, or the
15 public.

16 Revised Law

17 Sec. 4006.002. RULES. The commissioner may adopt rules as
18 necessary to implement this chapter. (V.T.I.C. Art. 21.15-6, Sec.
19 (g).)

20 Source Law

21 (g) The board may adopt rules as necessary to
22 implement this article.

23 Revisor's Note

24 Section (g), V.T.I.C. Article 21.15-6, refers to
25 the "board," meaning the State Board of Insurance.
26 Chapter 685, Acts of the 73rd Legislature, Regular
27 Session, 1993, abolished the board and transferred its
28 functions to the commissioner of insurance and the
29 Texas Department of Insurance. Throughout this
30 chapter, references to the board have been changed
31 appropriately.

32 [Sections 4006.003-4006.050 reserved for expansion]

33 SUBCHAPTER B. POWERS AND DUTIES OF DEPARTMENT

34 Revised Law

35 Sec. 4006.051. DISABILITY PROBATION ORDER. (a) The
36 department may order that an agent be placed on disability
37 probation if, after notice and an opportunity for a hearing, the

1 department determines that the agent is suffering from a
2 disability.

3 (b) The department may order disability probation for an
4 agent only if the agent demonstrates that:

5 (1) the disability can be successfully arrested and
6 treated while the agent is engaged in the agent's professional
7 business;

8 (2) the disability is unlikely to cause harm to the
9 public during the period of rehabilitation;

10 (3) adequate supervision of any necessary conditions
11 of the probation will occur; and

12 (4) the agent is capable of competently performing the
13 agent's professional duties. (V.T.I.C. Art. 21.15-6, Secs. (a)
14 (part), (b).)

15 Source Law

16 Art. 21.15-6. (a) After notice and an
17 opportunity for a hearing, the State Board of
18 Insurance may place an insurance agent on disability
19 probation if the board finds that the agent is
20 suffering from a disability. . . .

21 (b) An agent may not be placed on disability
22 probation unless the agent has demonstrated:

23 (1) a disability that can be successfully
24 arrested and treated while the agent is engaged in the
25 agent's professional business;

26 (2) the unlikelihood of any harm to the
27 public resulting from the disability during the period
28 of rehabilitation;

29 (3) adequate supervision of any necessary
30 conditions of the probation; and

31 (4) the ability to discharge the agent's
32 professional duties in a competent manner.

33 Revised Law

34 Sec. 4006.052. RESTITUTION. (a) The department may order
35 disability probation for an agent only if the agent makes full
36 restitution during the probation period to all insureds and other
37 persons harmed by the agent's:

38 (1) violation of this code or other laws regulating
39 the business of insurance in this state; or

40 (2) failure to comply with other professional
41 responsibilities.

42 (b) The department shall require the restitution described

1 by Subsection (a) as a condition of the probation. (V.T.I.C. Art.
2 21.15-6, Sec. (e).)

3 Source Law

4 (e) The board may not place an agent on
5 disability probation unless the agent makes full
6 restitution to all insureds and other persons harmed
7 by the agent's violation of this code or other laws
8 regulating the business of insurance in this state or
9 failure to comply with other professional
10 responsibilities. The restitution requirement must be
11 imposed as a condition of probation. The restitution
12 must be made in full during the term of the probation.

13 Revised Law

14 Sec. 4006.053. DURATION OF PROBATION. (a) If the
15 department orders disability probation, the department shall set
16 the probation for a specified period or until further order of the
17 department.

18 (b) The department may order a probation period that exceeds
19 the one-year maximum suspension authorized under Section
20 82.052(1). (V.T.I.C. Art. 21.15-6, Sec. (c).)

21 Source Law

22 (c) If the board orders disability probation,
23 the board shall set the probation for a specified
24 period or until further order of the board. The board
25 may order that the period of probation exceed the
26 one-year maximum term of suspension authorized under
27 Subdivision 7(a)(1) of Article 1.10 of this code.

28 Revised Law

29 Sec. 4006.054. PROBATION CONDITIONS. (a) An order
30 placing an agent on disability probation must state the probation
31 conditions.

32 (b) In establishing the probation conditions, the
33 department shall consider:

34 (1) the nature and circumstances of the agent's
35 conduct;

36 (2) the agent's history, character, and condition; and

37 (3) the nature of the agent's disability.

38 (c) The department may impose on the agent any of the
39 following probation conditions:

40 (1) periodic reports to the department;

1 (2) satisfactory completion of a course of study
2 required by the department;

3 (3) payment of costs, including reasonable attorney's
4 fees and other expenses, related to the proceedings before the
5 department;

6 (4) psychological evaluation, counseling, and
7 treatment;

8 (5) drug and alcohol abuse evaluation, counseling, and
9 treatment;

10 (6) abstinence from alcohol or drugs;

11 (7) mandatory attendance at meetings of Alcoholics
12 Anonymous, Narcotics Anonymous, or similar support groups;

13 (8) periodic random urine testing to screen for drug
14 and alcohol abuse; and

15 (9) any other probation condition that the department
16 considers appropriate. (V.T.I.C. Art. 21.15-6, Sec. (d).)

17 Source Law

18 (d) The order placing an agent on disability
19 probation must state the conditions of the probation.
20 In establishing the conditions, the board shall
21 consider the nature and circumstances of the conduct
22 of the agent, the history, character, and conditions
23 of the agent, and the nature of the agent's disability.
24 In addition to any other conditions considered
25 appropriate by the board, the board may impose the
26 following conditions on the agent:

27 (1) periodic reports to the board;

28 (2) satisfactory completion of a course of
29 study required by the board;

30 (3) psychological evaluation, counseling,
31 and treatment;

32 (4) payment of costs, including reasonable
33 attorney's fees and other expenses, related to the
34 proceedings before the board;

35 (5) drug and alcohol abuse evaluation,
36 counseling, and treatment;

37 (6) abstinence from alcohol or drugs;

38 (7) mandatory attendance at meetings of
39 Alcoholics Anonymous, Narcotics Anonymous, or similar
40 support groups; and

41 (8) periodic random urine testing to
42 screen for drug and alcohol abuse.

43 Revised Law

44 Sec. 4006.055. SUPERVISION DURING PROBATION. The
45 department shall supervise an agent placed on disability probation.
46 (V.T.I.C. Art. 21.15-6, Sec. (f) (part).)

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Source Law

(f) The board shall supervise agents placed on disability probation. . . .

Revised Law

Sec. 4006.056. EFFECT OF NONCOMPLIANCE. On a showing of an agent's failure to comply with the disability probation conditions, the department may:

- (1) revoke the probation; or
- (2) impose other conditions that the department considers necessary for the public's protection and the agent's rehabilitation. (V.T.I.C. Art. 21.15-6, Sec. (f) (part).)

Source Law

(f) . . . On a showing of a failure to comply with the conditions of probation, the board may revoke the probation or impose other conditions considered necessary by the board for the protection of the public and the rehabilitation of the agent.

[Chapters 4007-4050 reserved for expansion]

SUBTITLE B. AGENTS

CHAPTER 4051. PROPERTY AND CASUALTY AGENTS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 4051.001. APPLICABILITY OF CHAPTER 1786

Sec. 4051.002. REQUIREMENTS APPLICABLE TO CERTAIN AGENT CONTRACTS 1787

[Sections 4051.003-4051.050 reserved for expansion]

SUBCHAPTER B. GENERAL PROPERTY AND CASUALTY LICENSE

Sec. 4051.051. LICENSE REQUIRED. 1788

Sec. 4051.052. AUTHORITY TO WRITE ADDITIONAL LINES 1788

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[Sections 4051.055-4051.100 reserved for expansion]

SUBCHAPTER C. LIMITED PROPERTY AND CASUALTY LICENSE

Sec. 4051.101. LICENSE REQUIRED. 1790

Sec. 4051.102. DESIGNATION OF KINDS OF INSURANCE 1792

1 [Sections 4051.103-4051.150 reserved for expansion]

2 SUBCHAPTER D. INSURANCE SERVICE REPRESENTATIVE LICENSE

3 Sec. 4051.151. LICENSE REQUIRED. 1792

4 Sec. 4051.152. APPLICABILITY OF CERTAIN REQUIREMENTS 1793

5 [Sections 4051.153-4051.200 reserved for expansion]

6 SUBCHAPTER E. COUNTY MUTUAL AGENT LICENSE

7 Sec. 4051.201. LICENSE ISSUANCE. 1793

8 Sec. 4051.202. COURSE 1793

9 Sec. 4051.203. EXAMINATION 1794

10 Sec. 4051.204. INVESTIGATION BY DEPARTMENT 1795

11 Sec. 4051.205. WITHDRAWAL OF COMPANY'S AUTHORITY 1795

12 Sec. 4051.206. APPLICABILITY OF LIMITED LICENSE LAWS. 1795

13 [Sections 4051.207-4051.250 reserved for expansion]

14 SUBCHAPTER F. AGRICULTURAL INSURANCE AGENT

15 Sec. 4051.251. APPOINTMENT OF AGENT 1796

16 Sec. 4051.252. REQUIREMENTS FOR APPOINTMENT; PROCEDURE . . . 1797

17 Sec. 4051.253. ACCEPTANCE OF CERTAIN CONTINUING EDUCATION. . 1798

18 Sec. 4051.254. RULES 1798

19 [Sections 4051.255-4051.300 reserved for expansion]

20 SUBCHAPTER G. REGISTRATION OF HOME OFFICE EMPLOYEES

21 Sec. 4051.301. REGISTRATION AND DISCLOSURE REQUIRED; FEE . . 1798

22 Sec. 4051.302. CONTINUING EDUCATION REQUIREMENTS. 1799

23 Sec. 4051.303. SUSPENSION OF REGISTERED EMPLOYEE;

24 DISCIPLINARY ACTION AGAINST INSURER 1800

25 [Sections 4051.304-4051.350 reserved for expansion]

26 SUBCHAPTER H. TERMINATION OR SUSPENSION OF AGENT

27 CONTRACTS BY PROPERTY AND CASUALTY INSURERS

28 Sec. 4051.351. APPLICABILITY OF SUBCHAPTER 1801

29 Sec. 4051.352. SUSPENSION OF AGENT'S CONTRACT; OTHER

30 DEFINITIONS 1802

31 Sec. 4051.353. NOTICE REQUIRED BEFORE TERMINATION OR

32 SUSPENSION OF CONTRACT 1803

33 Sec. 4051.354. AUTOMATIC TERMINATION OF CONTRACT ON

34 WITHDRAWAL FROM STATE OR REDUCTION

1		OF BUSINESS	1804
2	Sec. 4051.355.	RENEWAL OF INSURANCE CONTRACTS AFTER NOTICE	
3		OF TERMINATION OR SUSPENSION	1805
4	Sec. 4051.356.	INSURER REFUSAL TO RENEW AGENT'S BUSINESS	
5		PROHIBITED	1806
6	Sec. 4051.357.	INSURER APPROVAL FOR NEW BUSINESS OR INCREASE	
7		IN LIABILITY	1806
8	Sec. 4051.358.	PROVISION OF UNDERWRITING STANDARDS TO AGENT	
9		WHOSE CONTRACT IS TERMINATED OR	
10		SUSPENDED	1807
11	Sec. 4051.359.	PAYMENT OF MONEY DUE INSURER	1808
12	Sec. 4051.360.	REVISION OF TERMINATION PROVISIONS OF AGENT'S	
13		CONTRACT	1808
14	Sec. 4051.361.	ADMINISTRATIVE PENALTY	1809
15	Sec. 4051.362.	ACTION FOR DAMAGES	1810

16 CHAPTER 4051. PROPERTY AND CASUALTY AGENTS

17 SUBCHAPTER A. GENERAL PROVISIONS

18 Revised Law

19 Sec. 4051.001. APPLICABILITY OF CHAPTER. (a) This
20 subchapter and Subchapters B-E and G apply to each agent of an
21 insurer authorized to engage in the business of property and
22 casualty insurance in this state.

23 (b) This subchapter and Subchapters B-E and G apply to each
24 person who performs the acts of an agent, as described by Section
25 4001.051, whether through an oral, written, electronic, or other
26 form of communication, by soliciting, negotiating, procuring, or
27 collecting a premium on an insurance contract offered by any kind of
28 insurer authorized to engage in the business of property and
29 casualty insurance in this state, including:

- 30 (1) a fidelity or surety company;
- 31 (2) a mutual insurance company, including a farm
32 mutual or a county mutual;
- 33 (3) a reciprocal or interinsurance exchange; and
- 34 (4) a Lloyd's plan. (V.T.I.C. Art. 21.14, Sec. 1(b).)

1 omitted law reads:

2 Art. 21.14

3 Sec. 1. (a) This article may be
4 cited as the Texas Property and Casualty
5 Agents License Act.

6 [Sections 4051.003-4051.050 reserved for expansion]

7 SUBCHAPTER B. GENERAL PROPERTY AND CASUALTY LICENSE

8 Revised Law

9 Sec. 4051.051. LICENSE REQUIRED. A person is required to
10 hold a general property and casualty license if the person acts as:

11 (1) an agent who writes property and casualty
12 insurance for an insurer authorized to engage in the business of
13 property and casualty insurance in this state;

14 (2) a subagent of a person who holds a license as an
15 agent under this chapter who solicits and binds insurance risks for
16 that agent; or

17 (3) an agent who writes any other kind of insurance as
18 required by the commissioner for the protection of the insurance
19 consumers of this state. (V.T.I.C. Art. 21.14, Sec. 2.)

20 Source Law

21 Sec. 2. A general property and casualty license
22 is required for each person who acts as:

23 (1) an agent writing property and casualty
24 insurance for an insurance carrier authorized to
25 provide property and casualty insurance coverage in
26 this state;

27 (2) a subagent of a person licensed as an
28 agent under this article who solicits and binds
29 insurance risks on behalf of that agent; or

30 (3) an agent writing any other type of
31 insurance as required by the commissioner for the
32 protection of the insurance consumers of this state.

33 Revised Law

34 Sec. 4051.052. AUTHORITY TO WRITE ADDITIONAL LINES. A
35 person who holds a general property and casualty license may, in
36 addition, write the kinds of insurance contracts described by:

37 (1) Section 4051.101 and Subchapter E; or

38 (2) Chapter 4055. (V.T.I.C. Art. 21.14, Sec. 3.)

39 Source Law

40 Sec. 3. A person who holds a general property
41 and casualty license issued under this subchapter may
42 write additional types of insurance contracts as

1 provided under:

- 2 (1) Sections 6 and 9 of this article; or
3 (2) Article 21.09 of this code.

4 Revised Law

5 Sec. 4051.053. AUTHORITY TO WRITE CERTAIN ACCIDENT AND
6 HEALTH INSURANCE. A person who holds a general property and
7 casualty license may, without holding a license under Chapter 4054,
8 write health and accident insurance for a property and casualty
9 insurer authorized to sell those insurance products in this state.
10 (V.T.I.C. Art. 21.14, Sec. 4.)

11 Source Law

12 Sec. 4. A person who holds a general property
13 and casualty license issued under this subchapter may
14 write health and accident insurance for a property and
15 casualty insurer authorized to sell those insurance
16 products in this state without holding a license
17 issued under Article 21.07-1 of this code.

18 Revised Law

19 Sec. 4051.054. DECEASED, DISABLED, OR INSOLVENT AGENTS;
20 EMERGENCY LICENSE. (a) If a property and casualty agent dies,
21 becomes disabled, or is found to be insolvent and unable to pay for
22 premiums as they become due to an insurer, the department may issue,
23 without examination, to an applicant for a property and casualty
24 agent license an emergency license on receipt of proof satisfactory
25 to the department that the emergency license is necessary to
26 preserve the agency assets of the deceased, disabled, or insolvent
27 agent.

28 (b) An emergency license is valid for 90 days in any 12
29 consecutive months and may be renewed by the department for an
30 additional 90 days during the 12-month period if the other
31 requirements of Subtitle A are satisfied. (V.T.I.C. Art. 21.14,
32 Sec. 5.)

33 Source Law

34 Sec. 5. In the event of the death or disability
35 of a property and casualty agent or if a property and
36 casualty agent is found to be insolvent and unable to
37 pay for premiums as they become due to an insurer, the
38 department may issue to an applicant for a property and
39 casualty license an emergency property and casualty
40 license without examination if it is established to
41 the satisfaction of the department that the emergency
42 license is necessary for the preservation of the

1 agency assets of a deceased, disabled, or insolvent
2 property and casualty agent. An emergency license is
3 valid for 90 days in any 12 consecutive months and may
4 be renewed by the department for an additional 90 days
5 during the 12-month period if the other requirements
6 of this subchapter are met.

7 [Sections 4051.055-4051.100 reserved for expansion]

8 SUBCHAPTER C. LIMITED PROPERTY AND CASUALTY LICENSE

9 Revised Law

10 Sec. 4051.101. LICENSE REQUIRED. (a) Except as provided
11 by Section 4051.052, a person is required to hold a limited property
12 and casualty license if the person acts as an agent who writes:

13 (1) job protection insurance as defined by Article
14 25.01;

15 (2) exclusively, insurance on growing crops under
16 Subchapter F;

17 (3) any form of insurance authorized under Chapter 911
18 for a farm mutual insurance company;

19 (4) exclusively, any form of insurance authorized to
20 be solicited and written in this state that relates to:

21 (A) the ownership, operation, maintenance, or
22 use of a motor vehicle designed for use on the public highways,
23 including a trailer or semitrailer, and the motor vehicle's
24 accessories or equipment; or

25 (B) the ownership, occupancy, maintenance, or
26 use of a manufactured home classified as personal property under
27 Section 2.001, Property Code;

28 (5) a prepaid legal services contract under Article
29 5.13-1 or Chapter 961;

30 (6) exclusively, an industrial fire insurance policy:

31 (A) covering dwellings, household goods, and
32 wearing apparel;

33 (B) written on a weekly, monthly, or quarterly
34 basis on a continuous premium payment plan; and

35 (C) written for an insurer exclusively engaged in
36 the business as described by Section 912.310;

37 (7) credit insurance, except as otherwise provided by

1 Chapter 4055; or

2 (8) any other kind of insurance, if holding a limited
3 property and casualty license to write that kind of insurance is
4 determined necessary by the commissioner for the protection of the
5 insurance consumers of this state.

6 (b) Subsection (a)(2) applies to an entity chartered by the
7 federal Farm Credit Administration, as provided by the farm credit
8 system under 12 U.S.C. Section 2001 et seq., as amended.

9 (c) This section does not apply to a person who wrote for the
10 previous calendar year:

11 (1) policies authorized by Chapter 911 for a farm
12 mutual insurance company that generated, in the aggregate, less
13 than \$50,000 in direct premium; or

14 (2) industrial fire insurance policies that
15 generated, in the aggregate, less than \$20,000 in direct premium.
16 (V.T.I.C. Art. 21.14, Secs. 6(a), (b), (d).)

17 Source Law

18 Sec. 6. (a) A limited property and casualty
19 license is required for each person who desires to act
20 as an agent writing:

21 (1) job protection insurance as defined by
22 Article 25.01 of this code;

23 (2) insurance only on growing crops under
24 Article 21.14-2 of this code;

25 (3) any form of insurance authorized under
26 Chapter 16 of this code for a farm mutual insurance
27 company;

28 (4) exclusively all forms of insurance
29 authorized to be solicited and written in this state
30 that cover the ownership, operation, maintenance, or
31 use of a motor vehicle that is designed for use on the
32 public highways, including a trailer or semitrailer,
33 and the motor vehicle's accessories or equipment;

34 (5) exclusively all forms of insurance
35 authorized to be solicited and written in this state
36 that relate to the ownership, occupancy, maintenance,
37 or use of a manufactured home that is classified as
38 personal property under Section 2.001, Property Code;

39 (6) prepaid legal services contracts under
40 Article 5.13-1 or Chapter 23 of this code;

41 (7) only industrial fire insurance
42 policies covering dwellings, household goods, and
43 wearing apparel written on a weekly, monthly, or
44 quarterly basis on a continuous premium payment plan
45 and written for an insurance company whose business is
46 devoted exclusively to that business as described by
47 Article 17.02 of this code;

48 (8) credit insurance, except as otherwise
49 provided by Article 21.09 of this code; or

50 (9) any other type of insurance as

1 required by the commissioner for the protection of the
2 insurance consumers of this state.

3 (b) Subsection (a)(2) of this section applies to
4 an entity chartered by the federal Farm Credit
5 Administration, as provided under the farm credit
6 system under 12 U.S.C. 2001 et seq., as amended.

7 (d) This section does not apply to a person who
8 wrote:

9 (1) policies, authorized under Chapter 16
10 of this code for a farm mutual insurance company, that
11 generated, in the aggregate, less than \$50,000 in
12 direct premium for the previous calendar year; or

13 (2) industrial fire insurance policies
14 that generated, in the aggregate, less than \$20,000 in
15 direct premium for the previous calendar year.

16 Revised Law

17 Sec. 4051.102. DESIGNATION OF KINDS OF INSURANCE. A person
18 who holds a limited property and casualty license may write only the
19 kind of insurance designated on the license. (V.T.I.C. Art. 21.14,
20 Sec. 6(c).)

21 Source Law

22 (c) A person who holds a limited property and
23 casualty license issued under this subchapter may
24 write only the types of insurance products designated
25 on the license by the department.

26 [Sections 4051.103-4051.150 reserved for expansion]

27 SUBCHAPTER D. INSURANCE SERVICE REPRESENTATIVE LICENSE

28 Revised Law

29 Sec. 4051.151. LICENSE REQUIRED. A person is required to
30 hold an insurance service representative license if the person is a
31 salaried employee who performs assigned duties only in an office of
32 a property and casualty agent, including explaining insurance
33 coverage, describing an insurance product, quoting insurance
34 premium rates, and issuing insurance binders only with the express
35 approval of the property and casualty agent who supervises the
36 license holder. (V.T.I.C. Art. 21.14, Sec. 8(a).)

37 Source Law

38 Sec. 8. (a) An insurance service
39 representative license is required for each person who
40 is employed on a salaried basis to perform assigned
41 duties only in the office of a property and casualty
42 agent, including explaining insurance coverage,
43 describing an insurance product, quoting insurance
44 premium rates, and issuing insurance binders only with
45 the express approval of the property and casualty
46 agent who supervises the insurance service
47 representative.

1 Revised Law

2 Sec. 4051.152. APPLICABILITY OF CERTAIN REQUIREMENTS. The
3 provisions of this title that apply to the holder of a general
4 property and casualty license apply to the holder of a license
5 issued under this subchapter, except that proof of financial
6 responsibility is not required for a person licensed only under
7 this subchapter. (V.T.I.C. Art. 21.14, Sec. 8(b).)

8 Source Law

9 (b) The provisions of this subchapter that apply
10 to a general license apply to a license issued under
11 this section, except that proof of financial
12 responsibility is not required of a person licensed
13 only as an insurance service representative.

14 [Sections 4051.153-4051.200 reserved for expansion]

15 SUBCHAPTER E. COUNTY MUTUAL AGENT LICENSE

16 Revised Law

17 Sec. 4051.201. LICENSE ISSUANCE. The department shall
18 issue a license to an individual applicant to act as an agent for a
19 county mutual insurance company under Chapter 912 on receipt of
20 certification from the company that the applicant has:

21 (1) completed a course of study and instruction in
22 compliance with this subchapter; and

23 (2) passed without aid a written examination
24 administered by the company. (V.T.I.C. Art. 21.14, Sec. 9(a)
25 (part).)

26 Source Law

27 Sec. 9. (a) The department shall issue a
28 license to act as an agent for a county mutual
29 insurance company under Chapter 17 of this code to an
30 individual applicant after receiving certification
31 from the insurance company that the applicant has:

32 (1) completed a course of study and
33 instruction . . . ; and

34 (2) passed without aid a written
35 examination administered by the insurance company.

36 Revised Law

37 Sec. 4051.202. COURSE. (a) To be eligible to receive a
38 license under this subchapter, an applicant must complete a course
39 of study and instruction offered by the applicable company on motor
40 vehicle insurance and insurance covering dwellings.

1 (b) The course of study and instruction must:
2 (1) be at least five hours in duration; and
3 (2) include instruction on:
4 (A) the policies to be sold; and
5 (B) the laws relating to the regulation of
6 insurance in this state. (V.T.I.C. Art. 21.14, Secs. 9(a) (part),
7 (b).)

8 Source Law

9 (a) [The department shall issue a license to act
10 as an agent for a county mutual insurance company under
11 Chapter 17 of this code to an individual applicant
12 after receiving certification from the insurance
13 company that the applicant has:]

14 (1) completed a course of study and
15 instruction on motor vehicle insurance and insurance
16 covering dwellings offered by the insurance company
17

18 (b) The course completed under Subsection (a) of
19 this section must be at least a five-hour course and
20 must include instruction on:

21 (1) the policies to be sold; and
22 (2) the laws relating to the regulation of
23 insurance in this state.

24 Revised Law

25 Sec. 4051.203. EXAMINATION. (a) The commissioner shall
26 prescribe a uniform examination for applicants that fairly tests
27 knowledge of the information contained in the course provided under
28 Section 4051.202.

29 (b) The department shall authorize a county mutual
30 insurance company to administer the examination after approval by
31 the department of a complete outline and explanation of the course
32 and the manner of conducting the examination. (V.T.I.C. Art.
33 21.14, Sec. 9(c).)

34 Source Law

35 (c) The commissioner shall authorize a county
36 mutual insurance company to administer an agent
37 examination as provided by Subsection (a) of this
38 section after approval by the commissioner of a
39 complete outline and explanation of the course of
40 study and instruction and the nature and manner of
41 conducting the examination for applicants. The
42 commissioner shall prescribe a uniform examination for
43 applicants that fairly addresses the information
44 contained in the approved course of study and
45 instruction.

1 Revisor's Note

2 Section 9(c), V.T.I.C. Article 21.14, refers to
3 the "nature and manner" of conducting an examination.
4 The revised law omits the reference to "nature"
5 because, in context, "nature" is included within the
6 meaning of "manner."

7 Revised Law

8 Sec. 4051.204. INVESTIGATION BY DEPARTMENT. The
9 department may investigate as necessary the manner of instruction
10 and the examination administered by a company under this
11 subchapter. (V.T.I.C. Art. 21.14, Sec. 9(d) (part).)

12 Source Law

13 (d) The department may investigate as necessary
14 the manner of instruction and the examination
15 administered by an insurance company under this
16 section. . . .

17 Revised Law

18 Sec. 4051.205. WITHDRAWAL OF COMPANY'S AUTHORITY. The
19 department may withdraw from a county mutual insurance company the
20 authority under this subchapter to offer instruction and administer
21 an examination. (V.T.I.C. Art. 21.14, Sec. 9(d) (part).)

22 Source Law

23 (d) . . . The department may withdraw from an
24 insurance company the authority under this section to
25 offer instruction and administer an examination.

26 Revised Law

27 Sec. 4051.206. APPLICABILITY OF LIMITED LICENSE
28 LAWS. Except as specifically provided by this subchapter, the
29 provisions of this title that apply to the holder of a limited
30 license apply to the holder of a license issued under this
31 subchapter. (V.T.I.C. Art. 21.14, Sec. 9(e).)

32 Source Law

33 (e) Except as specifically provided by this
34 section, the provisions of this subchapter that apply
35 to a limited license apply to a license issued under
36 this section.

37 [Sections 4051.207-4051.250 reserved for expansion]

1 SUBCHAPTER F. AGRICULTURAL INSURANCE AGENT

2 Revised Law

3 Sec. 4051.251. APPOINTMENT OF AGENT. (a) An insurer that
4 holds a valid certificate of authority to engage in the business of
5 insurance in this state and whose authority in this state and each
6 other jurisdiction in which the insurer is authorized to engage in
7 the business of insurance is limited to the business of insuring
8 risks on growing crops may, subject to this subchapter, appoint and
9 act through an agent licensed under Subchapter B, C, or E.

10 (b) An agent appointed under Subsection (a) may act as an
11 agent for more than one insurer but may act as an agent under this
12 subchapter only with respect to the business of insuring risks on
13 growing crops.

14 (c) This title applies to the licensing and regulation of an
15 agent appointed under this subchapter. (V.T.I.C. Art. 21.14-2,
16 Secs. 1, 3, 4.)

17 Source Law

18 Art. 21.14-2

19 Sec. 1. An insurance company that holds a valid
20 certificate of authority issued by this state to
21 authorize the company to engage in the insurance
22 business in this state, and whose authority in this
23 state and in each other jurisdiction in which the
24 company is licensed to do business is limited to the
25 transaction of the business of insurance of risks on
26 growing crops, may appoint and act through agents who
27 hold a license under Article 21.14 of this code,
28 subject to this article.

29 Sec. 3. A license holder appointed under this
30 article may act as an agent for more than one insurance
31 company, but may act as an agent under this article
32 only with respect to the business of insurance on
33 growing crops.

34 Sec. 4. This subchapter applies to the
35 licensing and regulation of an agent appointed under
36 this article.

37 Revisor's Note

38 Section 1, V.T.I.C. Article 21.14-2, provides
39 that certain insurers whose business is limited to
40 insuring risks on growing crops may "appoint and act
41 through agents who hold a license under Article 21.14
42 of this code." V.T.I.C. Article 21.14 is revised in

1 this chapter as Subchapters B, C, D, and E. The
2 revised law omits a reference to Subchapter D in the
3 revision of Section 1 because an insurance service
4 representative licensed under that subchapter may only
5 perform assigned duties in the office of a property and
6 casualty agent licensed under Subchapter B or C. In
7 context, it is clear that Section 1 properly refers
8 only to an "agent" and not to a "service
9 representative" working in an agent's office.

10 Revised Law

11 Sec. 4051.252. REQUIREMENTS FOR APPOINTMENT; PROCEDURE.

12 (a) To appoint an agent under this subchapter, an insurer must
13 submit a completed appointment form to the department and pay a
14 nonrefundable fee in an amount set by the department.

15 (b) The appointment form must be signed by a representative
16 of the insurer.

17 (c) The department shall approve an appointment unless the
18 department determines that the applicant does not meet the
19 requirements of this title.

20 (d) The department may waive any examination requirement
21 imposed by this title for a license applicant seeking an
22 appointment under this subchapter who has passed an examination as
23 required by Federal Crop Insurance Corporation guidelines for
24 administering the federal crop insurance program. (V.T.I.C. Art.
25 21.14-2, Secs. 2(a), (b), (c).)

26 Source Law

27 Sec. 2. (a) To appoint a license holder to act
28 as an agent under this article, an insurance company
29 must submit a completed appointment form to the
30 department and pay a nonrefundable fee in an amount
31 determined by the commissioner. The appointment form
32 must bear an endorsement signed by a representative of
33 an insurance company that meets the requirements of
34 Section 1 of this article.

35 (b) The commissioner of insurance shall approve
36 the appointment unless the commissioner determines
37 that the applicant does not meet the requirements of
38 this subchapter.

39 (c) The department may waive any examination
40 requirement imposed under this subchapter for a
41 license applicant seeking a company appointment under

1 this article if the applicant has successfully
2 completed an examination as required under the Federal
3 Crop Insurance Corporation guidelines for delivery of
4 the federal crop insurance program.

5 Revisor's Note

6 Section 2(a), V.T.I.C. Article 21.14-2, provides
7 that an appointment form must "bear an endorsement
8 signed by a representative" of an insurer. The revised
9 law omits the reference to the form bearing an
10 "endorsement" because, in context, that requirement is
11 included within the requirement that the form be
12 "signed."

13 Revised Law

14 Sec. 4051.253. ACCEPTANCE OF CERTAIN CONTINUING
15 EDUCATION. The department may accept continuing education hours
16 completed under the guidelines of the Federal Crop Insurance
17 Corporation as satisfying the continuing education requirements
18 imposed under this title. (V.T.I.C. Art. 21.14-2, Sec. 2(d).)

19 Source Law

20 (d) The department may, at its discretion,
21 accept continuing education hours completed under the
22 guidelines of the Federal Crop Insurance Corporation
23 as satisfying the continuing education requirements
24 imposed under this subchapter.

25 Revised Law

26 Sec. 4051.254. RULES. The commissioner may adopt rules
27 necessary to implement this subchapter and to meet the minimum
28 requirements of federal law, including regulations. (V.T.I.C.
29 Art. 21.14-2, Sec. 5.)

30 Source Law

31 Sec. 5. The commissioner may adopt rules
32 necessary to implement this article and to meet the
33 minimum requirements of federal law and regulations.

34 [Sections 4051.255-4051.300 reserved for expansion]

35 SUBCHAPTER G. REGISTRATION OF HOME OFFICE EMPLOYEES

36 Revised Law

37 Sec. 4051.301. REGISTRATION AND DISCLOSURE REQUIRED;
38 FEE. (a) A person is required to be registered with the
39 department if the person acts as a full-time home office salaried

1 employee who solicits or receives an application for the sale of
2 insurance through an oral, written, or electronic communication for
3 an insurer authorized to engage in the business of insurance in this
4 state.

5 (b) A person who registers under this section must submit a
6 nonrefundable registration fee in an amount set by the department.

7 (c) A person registered under this section shall disclose
8 that the person is registered on making an oral, written, or
9 electronic communication to solicit or receive an application for
10 the sale of insurance. (V.T.I.C. Art. 21.14, Secs. 7(a), (d), (e).)

11 Source Law

12 Sec. 7. (a) Each actual full-time home office
13 salaried employee of an insurance carrier licensed to
14 do business in this state who solicits or receives an
15 application for the sale of insurance through an oral,
16 written, or electronic communication shall register
17 with the department.

18 (d) Each registrant under this section shall
19 disclose the fact of the registration when making an
20 oral, written, or electronic communication to solicit
21 or receive an application for the sale of insurance.

22 (e) Each person who registers under this section
23 shall submit a nonrefundable registration fee in an
24 amount determined by the department.

25 Revisor's Note

26 Section 7(a), V.T.I.C. Article 21.14, refers to
27 an "actual full-time home office salaried employee."
28 The revised law omits "actual" as unnecessary. An
29 individual is not a full-time home office salaried
30 employee if the individual is not an actual full-time
31 salaried employee.

32 Revised Law

33 Sec. 4051.302. CONTINUING EDUCATION REQUIREMENTS. (a) An
34 insurer authorized to engage in the business of insurance in this
35 state whose general plan of operation includes the use of employees
36 described by Section 4051.301 shall certify to the department that
37 each of those employees receives at least 15 hours of continuing
38 education annually.

39 (b) Each continuing education course provided by the

1 insurer must be submitted to the department for certification as
2 provided by Chapter 4004.

3 (c) A person registered under this subchapter shall comply
4 with the continuing education requirements imposed by Chapter 4004
5 as if the person were a licensed agent.

6 (d) The continuing education required by this section must
7 be designed to give the employees:

8 (1) reasonable familiarity with:

9 (A) the broad principles of insurance;

10 (B) insurance licensing and regulatory laws; and

11 (C) the terms and conditions of the insurance
12 that the employees transact;

13 (2) a fair and general understanding of the duties of
14 an insurer to an insured; and

15 (3) training in ethical considerations. (V.T.I.C.
16 Art. 21.14, Sec. 7(b).)

17 Source Law

18 (b) An insurance carrier licensed to do business
19 in this state whose general plan of operation includes
20 the use of employees described by Subsection (a) of
21 this section shall certify to the department that each
22 of those employees receives at least 15 hours of
23 continuing education annually. Each continuing
24 education course provided by the insurance carrier
25 shall be submitted to the department for approval as
26 provided by Section 3, Article 21.01-1, of this code.
27 A person registered under this section shall comply
28 with the continuing education requirements adopted
29 under Section 3, Article 21.01-1, of this code, as if
30 the person were a licensed agent. The continuing
31 education must be designed to give the employee:

32 (1) reasonable familiarity with:

33 (A) the broad principles of
34 insurance;

35 (B) insurance licensing and
36 regulatory laws; and

37 (C) the terms and conditions of the
38 insurance that the registrant transacts; and

39 (2) a fair and general understanding of
40 the duties of an insurer to an insured, including
41 training in ethical considerations.

42 Revised Law

43 Sec. 4051.303. SUSPENSION OF REGISTERED EMPLOYEE;
44 DISCIPLINARY ACTION AGAINST INSURER. The registration of an
45 employee under this subchapter shall be suspended and the insurer

1 who employs the registered employee may be disciplined for any act
2 for which an agent may be disciplined under Subchapter C, Chapter
3 4005. (V.T.I.C. Art. 21.14, Sec. 7(c).)

4 Source Law

5 (c) The registration of an actual full-time home
6 office salaried employee shall be suspended and the
7 employer insurance carrier may be disciplined for any
8 act for which an agent may be disciplined under Article
9 21.01-2 of this code.

10 [Sections 4051.304-4051.350 reserved for expansion]

11 SUBCHAPTER H. TERMINATION OR SUSPENSION OF AGENT

12 CONTRACTS BY PROPERTY AND CASUALTY INSURERS

13 Revised Law

14 Sec. 4051.351. APPLICABILITY OF SUBCHAPTER. (a) Except
15 as provided by Subsection (b), this subchapter applies to each
16 contract between an agent and an insurer engaged in the business of
17 property and casualty insurance in this state.

18 (b) This subchapter does not apply to:

19 (1) the termination or suspension by an insurer of an
20 agent's contract because of:

21 (A) insolvency;

22 (B) abandonment;

23 (C) gross and wilful misconduct;

24 (D) failure to pay the insurer money due to the
25 insurer after receipt of a written demand; or

26 (E) revocation of the agent's license by the
27 department; or

28 (2) the termination or suspension by an insurer of an
29 agent's contract if the insurance policies and insurance business
30 are owned by the insurer rather than the agent. (V.T.I.C. Art.
31 21.11-1, Secs. 3, 4.)

32 Source Law

33 Sec. 3. The provisions of this article shall not
34 apply to the termination or suspension of an agent's
35 contract for insolvency, abandonment, gross and
36 willful misconduct, or failure to pay over to the
37 company money due to the company after his receipt of a
38 written demand therefor, or after revocation of the
39 agent's license by the State Board of Insurance; nor to

1 the termination or suspension of agents where the
2 policies and the insurance business is owned by the
3 company and not by the agent.

4 Sec. 4. All existing contracts presently in
5 effect between an agent and a company writing fire and
6 casualty insurance in the State of Texas are subject to
7 the provisions of this article.

8 Revisor's Note

9 (1) Section 3, V.T.I.C. Article 21.11-1, refers
10 to the State Board of Insurance. Chapter 685, Acts of
11 the 73rd Legislature, Regular Session, 1993, abolished
12 the board and transferred its functions to the
13 commissioner of insurance and the Texas Department of
14 Insurance. Throughout this subchapter, references to
15 the board have been changed appropriately.

16 (2) Section 4, V.T.I.C. Article 21.11-1, and
17 other sections revised in this subchapter refer to
18 "fire and casualty insurance." The revised law
19 substitutes "property and casualty insurance" for the
20 quoted phrase throughout this subchapter for
21 consistency with other provisions in this chapter and
22 because "property and casualty insurance" is the more
23 modern term used to describe that kind of insurance.

24 Revised Law

25 Sec. 4051.352. SUSPENSION OF AGENT'S CONTRACT; OTHER
26 DEFINITIONS. (a) For purposes of this subchapter, "suspension,"
27 with regard to an agent's contract, means the temporary cessation
28 of business relations between an insurer and an agent and refusal by
29 the insurer to accept insurance contracts submitted by the agent.
30 The term does not include a situation in which business is suspended
31 immediately after a natural disaster.

32 (b) The commissioner shall adopt reasonable rules to
33 provide definitions necessary to accomplish the purposes of this
34 subchapter. (V.T.I.C. Art. 21.11-1, Secs. 1(a) (part), (f).)

35 Source Law

36 (a) . . . As used in this article, "suspend"
37 means the temporary cessation of business relations
38 and refusal to accept insurance contract submitted by
39 the agent and shall not include situations in which

1 business is suspended immediately following a natural
2 disaster.

3 (f) The board shall promulgate reasonable rules
4 and regulations to provide for definitions as
5 necessary in the accomplishments of the purposes of
6 this article.

7 Revisor's Note

8 Section 1(f), V.T.I.C. Article 21.11-1, refers to
9 "rules and regulations." The reference to
10 "regulations" is omitted from the revised law because
11 under Section 311.005(5), Government Code (Code
12 Construction Act), a rule is defined to include a
13 regulation. That definition applies to the revised
14 law.

15 Revised Law

16 Sec. 4051.353. NOTICE REQUIRED BEFORE TERMINATION OR
17 SUSPENSION OF CONTRACT. (a) An insurer may not terminate or
18 suspend a contract with an appointed agent that has been in effect
19 for at least two years unless the insurer provides written notice of
20 the termination or suspension to the agent at least six months
21 before the date the termination or suspension takes effect.

22 (b) A contract that replaces or revises a contract that has
23 been in effect for at least two years is subject to this subchapter
24 if there has not been a material change in the ownership of the
25 agency. (V.T.I.C. Art. 21.11-1, Secs. 1(a) (part), (e).)

26 Source Law

27 Art. 21.11-1
28 Sec. 1. (a) After an agency contract has been
29 in effect for a period of two years an insurance
30 company writing fire and casualty insurance in this
31 state may not terminate or suspend an agency contract
32 with any appointed agent unless the company gives the
33 agent notice in writing of the termination or
34 suspension at least six months in advance. . . .

35 (e) An agency agreement that replaces, revises,
36 or in any other way takes the place of an agency
37 agreement that has been in effect for a period of two
38 years is subject to the provisions of this article so
39 long as there has been no material change in the
40 ownership of the agency.

41 Revisor's Note

42 (1) Section 1(e), V.T.I.C. Article 21.11-1,

1 refers to an agreement that "replaces, revises, or in
2 any other way takes the place of" another agreement.
3 The revised law omits the reference to "in any other
4 way takes the place of" because that phrase is included
5 in the meaning of "replaces."

6 (2) Section 1(e), V.T.I.C. Article 21.11-1,
7 refers to an "agency agreement," and Section 3,
8 V.T.I.C. Article 21.11-1, refers to an "agent's
9 contract." For purposes of consistency and because it
10 is the more commonly used term, the revised law in this
11 section and subsequent sections of this subchapter
12 refers to a "contract" to describe both the
13 relationship between the insurer and the agent and the
14 legal document that governs that relationship.

15 Revised Law

16 Sec. 4051.354. AUTOMATIC TERMINATION OF CONTRACT ON
17 WITHDRAWAL FROM STATE OR REDUCTION OF BUSINESS. (a) An insurer
18 that withdraws from this state or reduces the insurer's total
19 annual premium volume by at least 75 percent in any year is
20 considered to have terminated the contracts of the insurer's
21 agents. Except as provided by Subsection (b), the insurer shall
22 comply with the requirements of this subchapter.

23 (b) An insurer described by Subsection (a) shall renew each
24 contract for property and casualty insurance for the affected agent
25 for 24 months from the date of the notice of termination or
26 suspension of the contract.

27 (c) This section does not apply to the transfer of business
28 from an insurer to another insurer with which the agent has a
29 contract and that:

- 30 (1) is under common ownership; and
31 (2) is admitted to engage in the business of insurance
32 in this state. (V.T.I.C. Art. 21.11-1, Sec. 5.)

33 Source Law

34 Sec. 5. When an authorized insurer withdraws

1 from the state or reduces its total annual premium
2 volume by 75 percent or more in any year, such action
3 shall be deemed a termination of the insurer's agents
4 and the insurer shall comply with the provisions of
5 this article, except that the insurer shall renew all
6 contracts for fire and casualty insurance for the
7 agent for a period of 24 months from the date of the
8 notice of termination or suspension of the agency
9 agreement. This section does not apply to the transfer
10 of the business from an insurer to a company under
11 common ownership admitted to do business in this state
12 with which the agent has an agency contract.

13 Revised Law

14 Sec. 4051.355. RENEWAL OF INSURANCE CONTRACTS AFTER NOTICE
15 OF TERMINATION OR SUSPENSION. (a) Except as provided by
16 Subsection (b), an insurer that terminates or suspends an agent's
17 contract with an appointed agent shall renew all contracts for
18 property and casualty insurance for the agent during the six months
19 after the effective date of the termination or suspension of the
20 contract.

21 (b) The insurer may decline to renew an insurance contract
22 if any risk does not meet the insurer's current underwriting
23 standards. The insurer must provide at least 60 days' notice to the
24 agent of the insurer's intent not to renew the contract.

25 (c) An insurer that renews an insurance contract under this
26 section shall pay to the agent commissions for the renewal
27 according to the commission schedule that was in effect for the
28 agent before the insurer's decision to terminate or suspend the
29 agent's contract.

30 (d) An insurer that renews an insurance contract under this
31 section may not require the agent to convert from agency billing to
32 company billing during the termination period unless the agent
33 agrees in writing to the conversion. (V.T.I.C. Art. 21.11-1, Sec.
34 1(b) (part).)

35 Source Law

36 (b) The company shall renew all contracts for
37 fire and casualty insurance for the agent during a
38 period of six months from the effective date of the
39 termination or suspension, but in the event any risk
40 shall not meet current underwriting standards of the
41 company, the company may decline its renewal, provided
42 that the company shall give the agent not less than 60
43 days' notice of its intention not to renew the contract
44 of insurance. . . . An insurance company that is

1 renewing contracts of insurance under this subsection
2 shall pay to the terminated agent commissions for
3 those renewals according to the same commission
4 schedule that was in effect for that agent before the
5 company's decision to terminate the agency
6 contract. . . . An insurance company that is renewing
7 contracts of insurance under this subsection may not
8 require a terminated agent to convert from agency
9 billing to company billing during the termination
10 period unless that agent agrees to such conversion in
11 writing.

12 Revisor's Note

13 Section 1(b), V.T.I.C. Article 21.11-1, refers to
14 the "termination or suspension" of an agent and
15 subsequently to the "terminated agent" and the
16 "decision to terminate the agency contract." The
17 revised law adds appropriate references to the
18 suspension of an agent's contract in this section and
19 in the revision of other similar provisions in this
20 article because, in context, it is clear that the
21 provision applies not only to an agent who has been
22 terminated but also to an agent who has been suspended.

23 Revised Law

24 Sec. 4051.356. INSURER REFUSAL TO RENEW AGENT'S BUSINESS
25 PROHIBITED. During the term of the agent's contract, the insurer
26 may not refuse to renew business from the agent that complies with
27 the underwriting standards in effect for agents of the insurer
28 whose contracts have not been terminated or suspended. (V.T.I.C.
29 Art. 21.11-1, Sec. 2.)

30 Source Law

31 Sec. 2. During the term of the contract the
32 company shall not refuse to renew such business from
33 the agent as would be in accordance with the company's
34 current underwriting standards in effect for agents of
35 the company whose contracts have not been terminated
36 or suspended.

37 Revised Law

38 Sec. 4051.357. INSURER APPROVAL FOR NEW BUSINESS OR
39 INCREASE IN LIABILITY. An agent who receives notice of termination
40 or suspension of the agent's contract from an insurer may not write,
41 without the written approval of the insurer:

- 42 (1) any new business; or

1 (2) any increase in liability on a renewal policy or an
2 existing policy. (V.T.I.C. Art. 21.11-1, Sec. 1(c).)

3 Source Law

4 (c) No new business or increases in liability on
5 renewal or in force business shall be written by the
6 agent for the company after notice of termination
7 without the written approval of the company.

8 Revised Law

9 Sec. 4051.358. PROVISION OF UNDERWRITING STANDARDS TO AGENT
10 WHOSE CONTRACT IS TERMINATED OR SUSPENDED. (a) On providing
11 notice to an agent of termination or suspension of the agent's
12 contract under this subchapter, the insurer shall provide to the
13 agent the insurer's written underwriting standards. The standards
14 must conform to the underwriting standards that were in effect for
15 that agent before the insurer's decision to terminate or suspend
16 the agent's contract.

17 (b) An insurer may provide different underwriting standards
18 to different agents of the insurer if the standards are not used in
19 a way that prevents or discourages the renewal of the insurance
20 policies of an agent whose contract is terminated or suspended.
21 (V.T.I.C. Art. 21.11-1, Sec. 1(b) (part).)

22 Source Law

23 (b) . . . The company's written underwriting
24 standards shall be provided to its agents who have been
25 terminated at the same time the company first notifies
26 the agent of the company's intention to terminate the
27 agent's contract. The written underwriting standards
28 that the insurer furnishes to its terminated agents
29 must conform to the same underwriting standards that
30 were in effect for that agent before the company's
31 decision to terminate or suspend the agent's contract.
32 Notwithstanding the provisions of this section, an
33 insurance company may furnish different underwriting
34 standards to different agents of the company, so long
35 as such underwriting standards are not used in ways
36 that intentionally or otherwise serve to prevent or
37 discourage the renewal of the insurance policies of
38 terminated agents. . . .

39 Revisor's Note

40 (1) Section 1(b), V.T.I.C. Article 21.11-1,
41 provides that an insurer may furnish different
42 underwriting standards to different appointed agents
43 "[n]otwithstanding the provisions of this section."

1 The revised law omits the quoted language as
2 unnecessary because the remainder of the provision
3 being revised constitutes sufficient authority to
4 permit an insurer to furnish different standards to
5 different agents.

6 (2) Section 1(b), V.T.I.C. Article 21.11-1,
7 prohibits an insurer from providing standards that
8 "intentionally or otherwise" prevent or discourage the
9 renewal of certain insurance policies. The revised
10 law omits the quoted language as unnecessary because
11 "intentionally or otherwise" does not in any way limit
12 the prohibited conduct.

13 Revised Law

14 Sec. 4051.359. PAYMENT OF MONEY DUE INSURER. An insurer
15 shall allow an agent whose contract has been terminated or
16 suspended under this subchapter to pay to the insurer all money due
17 under the same accounts current payment terms in effect for agents
18 of the insurer whose contracts have not been terminated or
19 suspended. (V.T.I.C. Art. 21.11-1, Sec. 1(b) (part).)

20 Source Law

21 (b) . . . A terminated agent must be allowed to
22 pay to the company all sums due according to the same
23 accounts current payment terms that are in effect for
24 agents of the company who have not been
25 terminated. . . .

26 Revised Law

27 Sec. 4051.360. REVISION OF TERMINATION PROVISIONS OF
28 AGENT'S CONTRACT. (a) This subchapter does not prohibit an
29 amendment of or addendum to an agent's contract providing that the
30 contract may be terminated before the time required by this
31 subchapter if the agent agrees in writing to the earlier
32 termination.

33 (b) An insurer that proposes to revise the termination
34 provisions of an agent's contract must first present the agent with
35 a separate written impact statement that summarizes any effect that
36 the proposed amendment or addendum would have on the agent's rights

1 under this subchapter. (V.T.I.C. Art. 21.11-1, Sec. 1(d).)

2 Source Law

3 (d) Nothing contained in this Act shall ever be
4 deemed or construed to prohibit an amendment or
5 addendum subsequent to the inception date of the
6 original agency agreement providing in such subsequent
7 amendment or addendum that the original agency
8 agreement may be terminated at a sooner time than is
9 required by this Act provided the agent agrees in
10 writing to such sooner termination. An insurance
11 company that proposes to revise the termination
12 provisions of an existing agency agreement must first
13 present the agent with a separate written impact
14 statement that summarizes the effect, if any, that
15 such proposed subsequent amendment or addendum shall
16 have on the agent's rights as provided for by this
17 article.

18 Revisor's Note

19 Section 1(d), V.T.I.C. Article 21.11-1, refers to
20 an amendment or addendum made "subsequent to the
21 inception date" of an agreement. The revised law omits
22 the quoted language as unnecessary because an
23 amendment or addendum to an agreement may only be made
24 after the date of the original agreement.

25 Revised Law

26 Sec. 4051.361. ADMINISTRATIVE PENALTY. If the department
27 determines that an insurer has violated this subchapter, the
28 insurer is subject to an administrative penalty as provided by
29 Chapter 84 of not less than \$1,000 or more than \$10,000. (V.T.I.C.
30 Art. 21.11-1, Sec. 6.)

31 Source Law

32 Sec. 6. If it is found, after notice and an
33 opportunity to be heard as determined by the board,
34 that an insurance company has violated this article,
35 the insurance company shall be subject to an
36 administrative penalty under Article 1.10E of this
37 code of not less than \$1,000 nor more than \$10,000.

38 Revisor's Note

39 Section 6, V.T.I.C. Article 21.11-1, provides
40 that an administrative penalty may be imposed "after
41 notice and an opportunity to be heard as determined by
42 the board." The revised law omits the quoted language
43 because the procedures for imposition of an

1 administrative penalty by the Texas Department of
2 Insurance, including notice and hearing requirements,
3 are governed by Chapter 84 of this code.

4 Revised Law

5 Sec. 4051.362. ACTION FOR DAMAGES. An agent who has
6 sustained actual damages as a result of an insurer's violation of
7 this subchapter may bring an action against the insurer regardless
8 of whether the department has determined that there has been a
9 violation of this subchapter. (V.T.I.C. Art. 21.11-1, Sec. 7.)

10 Source Law

11 Sec. 7. Any agent who has sustained actual
12 damages as a result of a company's violation of this
13 article may maintain an action against the company,
14 without regard to whether or not there has been a
15 finding by the board that there has been a violation of
16 this article.

17 CHAPTER 4052. LIFE AND HEALTH INSURANCE COUNSELORS

18 SUBCHAPTER A. GENERAL PROVISIONS

19 Sec. 4052.001. DEFINITION 1811
20 Sec. 4052.002. USE OF CERTAIN TITLES NOT PROHIBITED 1813
21 Sec. 4052.003. APPLICABILITY OF OTHER LAW 1813
22 Sec. 4052.004. EXEMPTIONS 1814
23 Sec. 4052.005. RULES 1815

24 [Sections 4052.006-4052.050 reserved for expansion]

25 SUBCHAPTER B. LICENSE REQUIREMENTS

26 Sec. 4052.051. LICENSE REQUIRED. 1815
27 Sec. 4052.052. EXAMINATION 1816
28 Sec. 4052.053. APPOINTMENT TO ACT FOR INSURER NOT
29 REQUIRED 1817
30 Sec. 4052.054. LIMITS ON ADVERTISING 1817
31 Sec. 4052.055. DUAL COMPENSATION PROHIBITED. 1817
32 Sec. 4052.056. ELIGIBILITY FOR NEW LICENSE AFTER
33 REVOCATION 1818

34 [Sections 4052.057-4052.100 reserved for expansion]

35 SUBCHAPTER C. ENFORCEMENT OF COUNSELOR'S AGREEMENT

36 Sec. 4052.101. ENFORCEMENT OF AGREEMENT 1819

1 CHAPTER 4052. LIFE AND HEALTH INSURANCE COUNSELORS

2 SUBCHAPTER A. GENERAL PROVISIONS

3 Revised Law

4 Sec. 4052.001. DEFINITION. In this chapter, "life and
5 health insurance counselor" means a person who:

6 (1) for compensation, offers to examine or examines a
7 life, accident, or health insurance policy, a health benefit plan,
8 or an annuity or pure endowment contract to give advice or other
9 information regarding:

10 (A) the policy, plan, or contract terms,
11 conditions, benefits, coverage, or premiums; or

12 (B) the advisability of:

13 (i) changing, exchanging, converting,
14 replacing, surrendering, continuing, or rejecting a policy, plan,
15 or contract; or

16 (ii) accepting or procuring a policy, plan,
17 or contract from an insurer or health benefit plan issuer; or

18 (2) in any public manner:

19 (A) uses as a title:

20 (i) "insurance adviser";

21 (ii) "insurance analyst";

22 (iii) "insurance counselor";

23 (iv) "insurance specialist";

24 (v) "policyholders' adviser";

25 (vi) "policyholders' counselor"; or

26 (vii) any other similar title; or

27 (B) uses any other title indicating that the
28 person gives or is engaged in the business of giving advice or other
29 information to an insured, a beneficiary, or any other person
30 having an interest in a life, accident, or health insurance policy,
31 a health benefit plan, or an annuity or pure endowment contract.

32 (V.T.I.C. Art. 21.07-2, Sec. 1 (part).)

33 Source Law

34 Art. 21.07-2

1 to "altering [or] changing" a policy, plan, or
2 contract. The revised law omits "altering" because
3 that term is included in the meaning of "changing."

4 (5) Section 1, V.T.I.C. Article 21.07-2, refers
5 to a person who "in or on advertisements, cards, signs,
6 circulars or letterheads, or elsewhere, or in any
7 other way or manner by which public announcements are
8 made" uses certain titles. The revised law
9 substitutes "in any public manner" for the quoted
10 language because the meaning is the same, and the
11 substituted language is more concise.

12 Revised Law

13 Sec. 4052.002. USE OF CERTAIN TITLES NOT PROHIBITED. This
14 chapter does not prohibit a person who, through the completion of a
15 course of instruction recognized in the business of insurance, is
16 designated as a chartered life underwriter (CLU), chartered
17 financial consultant (ChFC), or certified financial planner (CFP)
18 from using that designation to indicate professional achievement.
19 (V.T.I.C. Art. 21.07-2, Sec. 1 (part).)

20 Source Law

21 Sec. 1. . . . This definition is not intended
22 to prevent a person who has obtained the professional
23 designation of chartered life underwriter (CLU),
24 chartered financial consultant (ChFC) or certified
25 financial planner (CFP) by completing a course of
26 instruction recognized within the business of
27 insurance from using that designation to indicate
28 professional achievement.

29 Revised Law

30 Sec. 4052.003. APPLICABILITY OF OTHER LAW. Except as
31 provided by this chapter, the provisions of this title that apply to
32 the licensing and regulation of agents apply to the licensing and
33 regulation of a life and health insurance counselor. (V.T.I.C.
34 Art. 21.07-2, Secs. 5(a) (part), 6.)

35 Source Law

36 Sec. 5. (a) Except as provided by this
37 article, licensing and regulation of a Life and Health
38 Insurance Counselor, as that term is defined herein,
39 shall be in the same manner and subject to the same

1 requirements as applicable to the licensing of agents
2 under this subchapter or as provided by any existing or
3 subsequent applicable law governing the licensing of
4 such agents, and all the provisions thereof are hereby
5 made applicable to applicants and licensees under this
6 article, except that

7 Sec. 6. Except as provided by this article, it
8 is the legislative intent, and it is hereby provided,
9 that the licensing and regulation of any person acting
10 as a Life and Health Insurance Counselor shall be
11 subject to the same statutes and requirements
12 applicable to the licensing and regulation of agents
13 under this subchapter. In event of subsequent
14 legislative enactment applicable to agents under this
15 subchapter, it is hereby provided that such statute
16 shall be applicable to any person acting as a Life and
17 Health Insurance Counselor, as defined in this
18 article.

19 Revisor's Note

20 Sections 5(a) and 6, V.T.I.C. Article 21.07-2,
21 refer to the applicability of other law and the
22 applicability of later versions of that other law.
23 Throughout this chapter, the revised law omits the
24 references to subsequent enactments or amendments as
25 unnecessary because under Section 311.027, Government
26 Code (Code Construction Act), a reference to a law
27 applies to all reenactments, revisions, or amendments
28 of the law.

29 Revised Law

30 Sec. 4052.004. EXEMPTIONS. This chapter does not apply to:

31 (1) a licensed agent for a life insurance company
32 while acting as an agent for the company;

33 (2) a licensed attorney at law of this state while
34 acting in the course or scope of the attorney's profession;

35 (3) a licensed public accountant of this state while
36 acting in the course or scope of the accountant's profession;

37 (4) a regular salaried officer or employee of an
38 authorized insurer issuing policies of life or health insurance
39 while acting for the insurer in discharging the duties of the
40 position or employment;

41 (5) an officer or employee of a bank or trust company
42 who does not receive compensation from a source other than the bank

1 or trust company for activities connected with the position or
2 employment; or

3 (6) an employer, an employer's officer or employee, or
4 a trustee of an employee benefit plan to the extent that the
5 employer, officer, employee, or trustee is engaged in the
6 administration or operation of an employee benefit program that
7 involves the use of insurance or annuities issued by a legal reserve
8 life insurer. (V.T.I.C. Art. 21.07-2, Sec. 3.)

9 Source Law

10 Sec. 3. The provisions of this article shall not
11 apply to the following persons:

12 (a) Licensed agents for a life insurance
13 company while acting for an insurer as its agent.

14 (b) Licensed attorneys at law of this
15 State when acting within the course or scope of their
16 profession.

17 (c) Licensed public accountants of this
18 State while acting within the course or scope of their
19 profession.

20 (d) A regular salaried officer or employee
21 of an authorized insurer issuing policies of life or
22 health insurance while acting for such insurer in
23 discharging the duties of the position or employment.

24 (e) An officer or employee of any bank or
25 trust company who receives no compensation from
26 sources other than the bank or trust company for such
27 activities connected with the employment.

28 (f) Employers or their officers or
29 employees, or the trustees of any employee benefit
30 plan, to the extent that such employers, officers,
31 employees or trustees are engaged in the
32 administration or operation of any program of employee
33 benefits involving the use of insurance or annuities
34 issued by a legal reserve life insurance company.

35 Revised Law

36 Sec. 4052.005. RULES. The commissioner may adopt rules
37 necessary to implement this chapter and to meet the minimum
38 requirements of federal law, including regulations. (V.T.I.C. Art.
39 21.07-2, Sec. 10.)

40 Source Law

41 Sec. 10. The commissioner may adopt rules
42 necessary to implement this article and to meet the
43 minimum requirements of federal law and regulations.

44 [Sections 4052.006-4052.050 reserved for expansion]

45 SUBCHAPTER B. LICENSE REQUIREMENTS

46 Revised Law

47 Sec. 4052.051. LICENSE REQUIRED. A person may not act as a

1 life and health insurance counselor unless the person holds a
2 license issued by the department under this chapter. (V.T.I.C.
3 Art. 21.07-2, Sec. 2.)

4 Source Law

5 Sec. 2. No person shall act as a Life and Health
6 Insurance Counselor, as defined in Section 1 of this
7 article, unless authorized so to act by a license
8 issued by the department under this article.

9 Revised Law

10 Sec. 4052.052. EXAMINATION. (a) An applicant for a life
11 and health insurance counselor license must take an examination
12 administered under Chapter 4002 that includes the following:

- 13 (1) fundamentals of life and health insurance;
14 (2) group life insurance, pensions, and health
15 insurance;
16 (3) law, trust, and taxation;
17 (4) finance and economics; and
18 (5) business insurance and estate planning.

19 (b) The department may not issue a life and health insurance
20 counselor license to a person unless the person has passed each part
21 of the examination.

22 (c) The department may schedule and give the examination.
23 (V.T.I.C. Art. 21.07-2, Secs. 5(b), (c) (part).)

24 Source Law

25 (b) An applicant for a Life and Health Insurance
26 Counselor's license must sit for an examination
27 administered under Article 21.01-1 of this code that
28 includes the following five subjects and subject
29 areas:

- 30 (1) Fundamentals of life and health
31 insurance;
32 (2) Group life insurance, pensions and
33 health insurance;
34 (3) Law, trust and taxation;
35 (4) Finance and economics; and
36 (5) Business insurance and estate
37 planning.

38 (c) No license shall be granted until such
39 individual shall have successfully passed each of the
40 five parts under Subsection (b) of this section. Such
41 examinations may be given and scheduled by the
42 Commissioner at the Commissioner's discretion. . . .

43 Revisor's Note

- 44 (1) Section 5(c), V.T.I.C. Article 21.07-2,

1 requires an applicant to "successfully" pass an
2 examination. The revised law omits "successfully"
3 because the requirement to pass the examination
4 includes success.

5 (2) Section 5(c), V.T.I.C. Article 21.07-2,
6 requires the Texas Department of Insurance to issue
7 licenses without examination to individuals who held a
8 life insurance counselor license on September 1, 1999.
9 The revised law omits the reference because the
10 provision is executed. The omitted law reads:

11 (c) . . . The department shall,
12 without further examination, issue a
13 license under this article to an individual
14 who, on September 1, 1999, holds a Life
15 Insurance Counselor license issued by the
16 department.

17 Revised Law

18 Sec. 4052.053. APPOINTMENT TO ACT FOR INSURER NOT
19 REQUIRED. An appointment to act for an insurer is not a condition
20 to the issuance of a life and health insurance counselor license.
21 (V.T.I.C. Art. 21.07-2, Sec. 5(a) (part).)

22 Source Law

23 (a) . . . an appointment to act for an insurer
24 shall not be a condition to the licensing of a Life and
25 Health Insurance Counselor.

26 Revised Law

27 Sec. 4052.054. LIMITS ON ADVERTISING. A life and health
28 insurance counselor may not advertise in any manner and may not
29 circulate materials indicating professional superiority or the
30 performance of professional service in a superior manner.
31 (V.T.I.C. Art. 21.07-2, Sec. 5(a) (part).)

32 Source Law

33 (a) . . . a Life and Health Insurance Counselor
34 shall not advertise in any manner and shall not
35 circulate materials indicating professional
36 superiority or the performance of professional service
37 in a superior manner; provided, however, that . . .

38 Revised Law

39 Sec. 4052.055. DUAL COMPENSATION PROHIBITED. A life and

1 health insurance counselor is not entitled to receive compensation
2 for the same service provided to the same client if the counselor:

3 (1) holds a license under Chapter 4054; and

4 (2) receives compensation for the service as an agent
5 licensed under that chapter. (V.T.I.C. Art. 21.07-2, Sec. 4a.)

6 Source Law

7 Sec. 4a. A person licensed under the provisions
8 of this article who is also licensed under Chapter 213,
9 Acts of the 54th Legislature, Regular Session, 1955
10 (Article 21.07-1, Vernon's Texas Insurance Code), as
11 amended, and who receives a commission or compensation
12 for services as an agent licensed under Chapter 213,
13 Acts of the 54th Legislature, Regular Session, 1955
14 (Article 21.07-1, Vernon's Texas Insurance Code), as
15 amended, shall not be entitled to receive a fee for the
16 same services to the same client as a Life and Health
17 Insurance Counselor.

18 Revised Law

19 Sec. 4052.056. ELIGIBILITY FOR NEW LICENSE AFTER
20 REVOCATION. If the department revokes a life and health insurance
21 counselor's license, the license holder is not eligible for a new
22 license until the second anniversary of the revocation date.
23 (V.T.I.C. Art. 21.07-2, Sec. 7 (part).)

24 Source Law

25 Sec. 7. . . . If the department revokes the
26 license, the license holder is not eligible for a new
27 license for two years after the effective date of the
28 license revocation.

29 Revisor's Note

30 Section 7, V.T.I.C. Article 21.07-2, states that
31 a person who violates this chapter is subject to
32 license revocation under V.T.I.C. Article 21.01-2.
33 Section 3A, Article 21.01-2, revised as Subchapter C,
34 Chapter 4005, of this code, applies by its own terms to
35 a person who violates Article 21.07-2. It is not
36 necessary to repeat that legal authority here. The
37 omitted law reads:

38 Sec. 7. A person who commits a
39 violation of this article is subject to
40 license revocation under Article 21.01-2 of
41 this code. . . .

42 [Sections 4052.057-4052.100 reserved for expansion]

1 SUBCHAPTER C. ENFORCEMENT OF COUNSELOR'S AGREEMENT

2 Revised Law

3 Sec. 4052.101. ENFORCEMENT OF AGREEMENT. A life and health
4 insurance counselor, or a person acting on the counselor's behalf,
5 may enforce an agreement between the counselor and a person, firm,
6 or corporation relating to the services of the counselor only if:

7 (1) the agreement is in writing;

8 (2) the agreement is executed in duplicate by the
9 person, firm, or corporation to be charged;

10 (3) a duplicate is delivered to and retained by the
11 person, firm, or corporation when executed; and

12 (4) the agreement specifies:

13 (A) the amount of the compensation paid or to be
14 paid to the counselor; and

15 (B) the services to be provided by the counselor.

16 (V.T.I.C. Art. 21.07-2, Sec. 4 (part).)

17 Source Law

18 Sec. 4. No contract or agreement between a Life
19 and Health Insurance Counselor, as defined in this
20 article, and any other person, firm or corporation,
21 relating to the activities, services, advice,
22 recommendations or information referred to in Section
23 1 of this article, shall be enforceable by or on behalf
24 of such Life and Health Insurance Counselor unless it
25 is in writing and executed in duplicate by the person,
26 firm or corporation to be charged, nor unless one of
27 said duplicates is delivered to and retained by such
28 person, firm or corporation when executed, nor unless
29 such contract or agreement plainly specifies the
30 amount of the fee paid or to be paid by such person,
31 firm or corporation, and the services to be rendered by
32 such Life and Health Insurance Counselor;

33 Revisor's Note

34 (1) Section 4, V.T.I.C. Article 21.07-2, refers
35 to a "contract or agreement." The revised law omits
36 "contract" as unnecessary because a contract is a type
37 of agreement.

38 (2) Section 4, V.T.I.C. Article 21.07-2, refers
39 to "the activities, services, advice, recommendations
40 or information referred to in Section 1 of this
41 article." The revised law substitutes "services of the

1 [life and health insurance] counselor" for the quoted
2 language because the meaning is the same, and the
3 substituted language is more concise.

4 (3) Section 4, V.T.I.C. Article 21.07-2, states
5 that the section does not apply to a person exempted
6 under Section 3 of that article. The revised law omits
7 the reference because Section 3, revised in this
8 chapter as Section 4052.004, provides sufficient
9 authority as to who is exempted under the article. The
10 omitted law reads:

11 Sec. 4. . . . provided, however,
12 that the foregoing provisions shall not be
13 applicable to any of the persons set out in
14 Section 3 of this article.

15 Revisor's Note
16 (End of Chapter)

17 (1) The revised law omits Section 8, V.T.I.C.
18 Article 21.07-2, providing that the article is
19 severable, because it duplicates Section 311.032,
20 Government Code (Code Construction Act), applicable to
21 the revised law, and Section 312.013, Government Code.
22 Those provisions state that a provision of a statute is
23 severable from each other provision that can be given
24 effect. The omitted law reads:

25 Sec. 8. Should any Section or part of
26 this article be held to be invalid for any
27 reason, such holding shall not be construed
28 as affecting the validity of any of the
29 remaining Sections or parts of this
30 article, it being the legislative intent
31 that the remainder of this article shall
32 stand, notwithstanding the invalidity of
33 any Section or part of this article.

34 (2) Section 9, V.T.I.C. Article 21.07-2, states
35 that a life and health insurance counselor shall
36 complete continuing education as required by
37 department rules or applicable articles of this code.
38 Sections 5(a) and 6, Article 21.07-2, revised in this
39 chapter as Section 4052.003, state that the provisions
40 of this title that apply to the regulation of agents

1 apply to the regulation of life and health insurance
 2 counselors. V.T.I.C. Article 21.01-1, revised in this
 3 code as Chapter 4004, provides the continuing
 4 education requirements applicable to agents and, as a
 5 result of Sections 5(a) and 6, V.T.I.C. Article
 6 21.07-2, to life and health insurance counselors. It
 7 is not necessary to specifically refer in this chapter
 8 to those continuing education requirements. The
 9 omitted law reads:

10 Sec. 9. A person who holds a license
 11 issued under this article shall complete
 12 continuing education as required by rules
 13 of the department or any applicable article
 14 of this code.

15 (3) Section 11, V.T.I.C. Article 21.07-2,
 16 refers to the earlier version of the law, which was
 17 redesignated as V.T.I.C. Article 21.07-2. The revised
 18 law omits the reference for the reason stated in the
 19 revisor's note to Section 4052.003. The omitted law
 20 reads:

21 Sec. 11. A reference in any law to
 22 Chapter 29, Acts of the 54th Legislature,
 23 Regular Session, 1955, means this article.

24 CHAPTER 4053. MANAGING GENERAL AGENTS

25 SUBCHAPTER A. GENERAL PROVISIONS

26 Sec. 4053.001. DEFINITIONS 1822
 27 Sec. 4053.002. EXCEPTION. 1824
 28 Sec. 4053.003. INAPPLICABILITY OF CHAPTER. 1825
 29 Sec. 4053.004. REGULATION OF MANAGING GENERAL AGENTS. 1826
 30 Sec. 4053.005. RULES 1826

31 [Sections 4053.006-4053.050 reserved for expansion]

32 SUBCHAPTER B. LICENSE REQUIREMENTS

33 Sec. 4053.051. LICENSE REQUIRED; EXEMPTIONS. 1827
 34 Sec. 4053.052. ISSUANCE OF TEMPORARY OR EMERGENCY LICENSE . . 1828
 35 Sec. 4053.053. SINGLE LICENSE REQUIRED. 1829
 36 Sec. 4053.054. NOTICE AND APPROVAL OF APPOINTMENT 1829
 37 Sec. 4053.055. LAPSE OF LICENSE 1831

1 [Sections 4053.056-4053.100 reserved for expansion]

2 SUBCHAPTER C. POWERS AND DUTIES OF MANAGING GENERAL AGENTS

3 Sec. 4053.101. GENERAL POWERS AND DUTIES 1831
4 Sec. 4053.102. CONTRACTS 1832
5 Sec. 4053.103. ACCOUNT REPORT 1834
6 Sec. 4053.104. SEPARATE RECORDS 1834
7 Sec. 4053.105. ESCROW ACCOUNT 1835
8 Sec. 4053.106. FIDUCIARY CAPACITY 1835
9 Sec. 4053.107. FINANCIAL EXAMINATION 1836
10 Sec. 4053.108. REQUIRED NOTICES TO DEPARTMENT 1836
11 Sec. 4053.109. REINSURANCE 1838
12 Sec. 4053.110. REDEMPTION OF CORPORATE SHARES 1839

13 [Sections 4053.111-4053.150 reserved for expansion]

14 SUBCHAPTER D. ENFORCEMENT

15 Sec. 4053.151. DISCIPLINARY ACTION 1840
16 Sec. 4053.152. GUARANTY FUND REIMBURSEMENT 1840

17 CHAPTER 4053. MANAGING GENERAL AGENTS

18 SUBCHAPTER A. GENERAL PROVISIONS

19 Revised Law

20 Sec. 4053.001. DEFINITIONS. In this chapter:

21 (1) "Affiliate" means a person who is classified as an
22 affiliate under Section 823.003(a).

23 (2) "Insurer" means an insurance company, carrier,
24 corporation, reciprocal or interinsurance exchange, mutual,
25 association, county mutual insurance company, Lloyd's plan, or
26 other insurance carrier authorized to engage in the business of
27 insurance in this state.

28 (3) "Managing general agent" means a person, firm, or
29 corporation that has supervisory responsibility for the local
30 agency and field operations of an insurer in this state or that is
31 authorized by an insurer to accept or process on the insurer's
32 behalf insurance policies produced and sold by other agents.

33 (V.T.I.C. Art. 21.07-3, Secs. 2(a) (part), (b) (part), (e).)

1 (c) "Commissioner" shall mean
2 the Commissioner of Insurance.

3 (4) Section 2(d), V.T.I.C. Article 21.07-3,
4 refers to the State Board of Insurance. Chapter 685,
5 Acts of the 73rd Legislature, Regular Session, 1993,
6 abolished the board and transferred its functions to
7 the commissioner of insurance and the Texas Department
8 of Insurance. Throughout this chapter, references to
9 the board have been changed appropriately. The
10 omitted law reads:

11 (d) "Board" shall mean the
12 State Board of Insurance.

13 (5) Section 2(e), V.T.I.C. Article 21.07-3,
14 defines "affiliate" and "affiliated" to have the
15 meaning "assigned by Section 2(a), Article 21.49-1,
16 Insurance Code." Section 2(a), Article 21.49-1,
17 Insurance Code, revised as Section 823.003(a) of this
18 code, refers to the classification of certain persons
19 as affiliates. The revised law is drafted
20 accordingly.

21 Revised Law

22 Sec. 4053.002. EXCEPTION. An agent licensed under
23 Subchapter E of Chapter 981, Subchapters B-E of Chapter 4051, or
24 Chapter 4056 is not a managing general agent unless the agent
25 accepts 50 percent or more of the agent's total annual business or
26 does \$500,000 or more of total annual business as measured by
27 premium volume, whichever amount is less, from insurance policies
28 produced and sold by other agents. (V.T.I.C. Art. 21.07-3, Sec.
29 2(a) (part).)

30 Source Law

31 (a) ["Managing General Agent" shall
32 mean] The term does not include an agent
33 licensed under Article 1.14-2, 21.11, or 21.14,
34 Insurance Code, unless that agent accepts 50 percent
35 or more of his total annual business or does more than
36 \$500,000 or more of total annual business, whichever
37 amount is less, as measured by premium volume from
38 insurance policies produced and sold by other
39 agents. . . .

1 Revised Law

2 Sec. 4053.003. INAPPLICABILITY OF CHAPTER. This chapter
3 does not apply to:

4 (1) the transaction of the business of life, health,
5 and accident insurance, including variable life insurance and
6 variable annuity contracts;

7 (2) a full-time salaried employee of an insurer acting
8 for and in connection with the insurance business of the insurer; or

9 (3) an adjuster or inspector of risks for an insurer.

10 (V.T.I.C. Art. 21.07-3, Secs. 2(b) (part), 16.)

11 Source Law

12 (b) ["Company," "Carrier," or "Insurer"
13 shall mean] . . . excepting, however, those which
14 write only life, health and accident insurance and
15 variable life insurance and variable annuity
16 contracts.

17 Sec. 16. No provisions of this Act shall apply
18 to the transaction of the Life, Health and Accident
19 Insurance business nor shall it apply to any of the
20 following:

21 (a) Any actual full-time salaried employee
22 of any insurance company or carrier licensed to do
23 business in Texas while acting for, and in connection
24 with the insurance business of, such company or
25 carrier.

26 (b) Any adjuster of losses, or inspector
27 of risks, for an insurance company or carrier licensed
28 to do business in Texas.

29 Revisor's Note

30 (1) Section 16(a), V.T.I.C. Article 21.07-3,
31 refers to an "actual full-time salaried employee."
32 The revised law omits "actual" as unnecessary. An
33 individual is not a full-time salaried employee if the
34 individual is not an actual full-time salaried
35 employee.

36 (2) Section 16(b), V.T.I.C. Article 21.07-3,
37 refers to an "adjuster of losses." V.T.I.C. Article
38 21.07-4, revised as Chapter 4101 of this code,
39 regulates insurance adjusters. The defined term in
40 that chapter for an insurance adjuster is "adjuster,"
41 and the revised law is drafted accordingly.

1 Revised Law

2 Sec. 4053.004. REGULATION OF MANAGING GENERAL
3 AGENTS. This title applies to the licensing and regulation of a
4 person acting as a managing general agent. (V.T.I.C. Art. 21.07-3,
5 Sec. 19(a).)

6 Source Law

7 Sec. 19. (a) Subchapter A, Chapter 21,
8 Insurance Code, applies to the licensing and
9 regulation of a person acting as a managing general
10 agent.

11 Revised Law

12 Sec. 4053.005. RULES. The commissioner may adopt
13 reasonable rules for the administration of this chapter. (V.T.I.C.
14 Art. 21.07-3, Sec. 21.)

15 Source Law

16 Sec. 21. The administration of this Act shall be
17 vested in the commissioner, who may establish, and
18 from time to time amend, reasonable rules for the
19 administration of this Act.

20 Revisor's Note

21 (1) Section 21, V.T.I.C. Article 21.07-3,
22 provides that the administration of the article "shall
23 be vested in the commissioner." The revised law omits
24 the provision as unnecessary because Section 31.021(a)
25 of this code, applicable to the revised law, provides
26 that the commissioner of insurance is the chief
27 administrative officer of the Texas Department of
28 Insurance and shall administer this code and other
29 insurance laws of this state.

30 (2) Section 21, V.T.I.C. Article 21.07-3,
31 provides that the commissioner of insurance may "from
32 time to time amend" rules adopted under that section.
33 The revised law omits the quoted language as
34 unnecessary. The authority to adopt rules includes
35 the authority to amend those rules.

1 a managing general agent as provided by this chapter.

2 (c) Notwithstanding Subsection (b), the managing general
3 agent shall execute on the insurer's behalf a contract entered into
4 with an agent. (V.T.I.C. Art. 21.07-3, Sec. 3.)

5 Source Law

6 Sec. 3. It shall be unlawful for any person,
7 firm or corporation to act as a managing general agent
8 in behalf of any insurance company or carrier without
9 having in force the license provided for herein,
10 except that no license shall be required if the
11 applicant is a business corporation authorized to do
12 business in Texas, all of whose outstanding stock is
13 solely owned by an insurance company or carrier
14 licensed to do business in Texas, whose business
15 affairs are completely controlled by such insurance
16 company or carrier and the principal purpose for which
17 the corporation exists is to facilitate the
18 accumulation of commissions from the insurance company
19 or carrier and its subsidiaries and affiliates for the
20 account of and payment to an agent who could otherwise
21 lawfully receive such commission direct from the
22 insurance company or carrier and its subsidiaries and
23 affiliates and the corporation does no other act of a
24 managing general agent as provided for in this
25 article; provided, however, that any contracts entered
26 into with agents shall be executed by the managing
27 general agent in behalf of the insurance company or
28 carrier.

29 Revisor's Note

30 Section 3, V.T.I.C. Article 21.07-3, refers to a
31 managing general agent acting "in behalf of any
32 insurance company or carrier." The revised law omits
33 the quoted language as unnecessary because the
34 definition of a managing general agent provided by
35 Section 2(a), V.T.I.C. Article 21.07-3, revised as
36 Section 4053.001(3), includes the concept of the agent
37 operating on behalf of an insurer.

38 Revised Law

39 Sec. 4053.052. ISSUANCE OF TEMPORARY OR EMERGENCY
40 LICENSE. The commissioner may, without requiring an examination,
41 issue a temporary or emergency license under this chapter to an
42 applicant for a period not to exceed six months:

43 (1) on the death or disability of a managing general
44 agent or for another good cause satisfactory to the commissioner;
45 and

1 (2) if the applicant meets the other requirements of
2 this chapter. (V.T.I.C. Art. 21.07-3, Sec. 7.)

3 Source Law

4 Sec. 7. In the event of death or disability of a
5 managing general agent or for other good cause
6 satisfactory to the commissioner, he may issue to an
7 applicant a temporary or emergency license for a
8 period not longer than six months, without requiring
9 an examination, provided the other requirements of
10 this Act are met.

11 Revised Law

12 Sec. 4053.053. SINGLE LICENSE REQUIRED. A license issued
13 under this chapter entitles the license holder to represent or act
14 for one or more insurers as a managing general agent. The license
15 holder is not required to hold a separate license for each insurer
16 the license holder represents. (V.T.I.C. Art. 21.07-3, Sec.
17 11(a).)

18 Source Law

19 Sec. 11. (a) Any license issued under this Act
20 shall entitle the licensee to represent or act for one
21 or more companies or carriers as a managing general
22 agent. A separate license for each individual company
23 or carrier represented by a licensee shall not be
24 required.

25 Revised Law

26 Sec. 4053.054. NOTICE AND APPROVAL OF APPOINTMENT. (a)
27 Each appointment to act as a managing general agent shall be
28 reported to the commissioner on a form prescribed by the
29 commissioner.

30 (b) The form must include:

31 (1) the details required by rules adopted under this
32 chapter;

33 (2) the insurer's name and identifying number;

34 (3) the managing general agent's name and address;

35 (4) a statement by an officer of the insurer that the
36 officer or the officer's agent has personal knowledge that the
37 managing general agent has had experience or instruction that
38 qualifies the agent to act as a managing general agent;

39 (5) a statement of whether the managing general agent

1 may exercise claim settlement authority for the insurer and, if so:

2 (A) whether that authority exceeds \$25,000 on any
3 one claim; and

4 (B) whether that authority includes third-party
5 liability other than property damage; and

6 (6) a statement of whether funds exceeding \$100,000
7 are customarily held by the managing general agent to pay losses and
8 loss adjustment expenses for the insurer.

9 (c) For each additional appointment for which a managing
10 general agent applies, the agent shall pay a nonrefundable fee in an
11 amount not to exceed \$16 as determined by the department.

12 (d) If approval of an additional appointment is not received
13 from the commissioner before the eighth day after the date the
14 commissioner receives the completed application and fee, the
15 managing general agent and insurer may assume, in the absence of
16 notice of disapproval from the commissioner, that the commissioner
17 approves the application and the managing general agent may act for
18 the insurer. (V.T.I.C. Art. 21.07-3, Secs. 11(c), (d), (e).)

19 Source Law

20 (c) Each appointment to act as a managing
21 general agent must be reported to the commissioner on
22 forms required by him and in the detail required by
23 rules adopted under this Act. The forms shall include
24 a statement by an officer of each company or carrier
25 that the officer or agent has personal knowledge that
26 the applicant has had experience or instruction that
27 would qualify the applicant as a managing general
28 agent. The forms shall include the following:

29 (1) the name of the company or carrier with
30 its company number;

31 (2) the name and address of the managing
32 general agent;

33 (3) a statement of whether the managing
34 general agent has claim settlement authority for the
35 company or carrier and whether that authority exceeds
36 \$25,000 on any one claim and whether that authority
37 includes third party liability other than property
38 damage; and

39 (4) a statement indicating if funds
40 exceeding \$100,000 are customarily held by the
41 managing general agent for the purpose of paying
42 losses and loss adjustment expenses for the company or
43 carrier.

44 (d) For each additional appointment for which
45 the agent applies, the agent shall be required to pay a
46 nonrefundable fee in an amount not to exceed \$16 as
47 determined by the State Board of Insurance.

48 (e) If approval of the additional appointment is

1 not received from the commissioner before the eighth
2 day after the date on which the completed application
3 and fee were received by the commissioner, the agent
4 and the insurance carrier, in the absence of notice of
5 disapproval, may assume that the commissioner approves
6 the application, and the agent may act for the
7 insurance carrier.

8 Revisor's Note

9 Sections 11(c)-(e), V.T.I.C. Article 21.07-3,
10 refer to a "managing general agent," an "applicant,"
11 and an "agent." Each of the terms refers, in context,
12 to an applicant for approval of an appointment as a
13 managing general agent. The revised law substitutes
14 "managing general agent" for those terms for
15 consistency of terminology and because the applicant
16 has already been appointed as a managing general agent
17 and is applying for approval of that appointment.

18 Revised Law

19 Sec. 4053.055. LAPSE OF LICENSE. If a license holder is
20 not appointed or under appointment to represent an insurer at the
21 time the license is subject to renewal, the license lapses and the
22 commissioner shall deny the renewal application. (V.T.I.C. Art.
23 21.07-3, Sec. 11(b).)

24 Source Law

25 (b) Any license issued under this Act shall
26 lapse, and the application for renewal shall be
27 denied, if the licensee is not appointed or under
28 appointment to represent any company or carrier at the
29 time of renewal.

30 [Sections 4053.056-4053.100 reserved for expansion]

31 SUBCHAPTER C. POWERS AND DUTIES OF MANAGING GENERAL AGENTS

32 Revised Law

33 Sec. 4053.101. GENERAL POWERS AND DUTIES. A managing
34 general agent acting for an insurer may:

- 35 (1) receive and pass on daily reports and monthly
36 accounts;
- 37 (2) receive and be responsible for agency balances;
- 38 (3) handle the adjustment of losses; or
- 39 (4) appoint or direct general property and casualty

1 agents in this state. (V.T.I.C. Art. 21.07-3, Sec. 2(a) (part).)

2 Source Law

3 (a) . . . A managing general agent may
4 perform any of the following acts for a company or
5 carrier: receive and pass upon daily reports and
6 monthly accounts; receive and be responsible for
7 agency balances; handle the adjustment of losses; or,
8 appoint or direct local recording agents, state
9 agents, or special agents within this state, or any
10 part thereof.

11 Revisor's Note

12 (1) Section 2(a), V.T.I.C. Article 21.07-3,
13 refers to "local recording agents, state agents, or
14 special agents." Throughout this chapter, the revised
15 law substitutes "general property and casualty agent"
16 for "local recording agent" because V.T.I.C. Article
17 21.14, as amended by Article 3, Chapter 703, Acts of
18 the 77th Legislature, Regular Session, 2001, replaced
19 the category of "local recording agent" with a new
20 licensing category, that of "general property and
21 casualty agent." In addition, the revised law omits
22 the references to "state agents" and "special agents"
23 because those are obsolete terms for property
24 insurance agents and those types of agents are
25 included in the category of "general property and
26 casualty agent."

27 (2) Section 2(a), V.T.I.C. Article 21.07-3,
28 refers to agents appointed within this state "or any
29 part thereof." The revised law omits the quoted
30 language for the reason stated in Revisor's Note (1) to
31 Section 4053.001.

32 Revised Law

33 Sec. 4053.102. CONTRACTS. (a) An insurer may not accept
34 business from a managing general agent and the agent may not place
35 business with the insurer without a written contract that
36 addresses:

37 (1) the responsibilities of each party;

- 1 (2) cancellation or termination;
2 (3) reports, records, and auditing; and
3 (4) if applicable:
4 (A) premium volume limits;
5 (B) appointment or cancellation of agents;
6 (C) claims settlement;
7 (D) underwriting; and
8 (E) reinsurance.

9 (b) The commissioner may adopt rules establishing
10 requirements for a contract with a managing general agent.

11 (c) A contract with a managing general agent and a report or
12 record submitted under that contract are subject to review by the
13 department under Section 38.001. (V.T.I.C. Art. 21.07-3, Sec. 3A.)

14 Source Law

15 Sec. 3A. (a) A company may not accept business
16 from a managing general agent and a managing general
17 agent may not place business with a company unless
18 there is a valid written contract relating to
19 responsibilities of both parties, cancellation or
20 termination, reports, records, auditing, and, if
21 applicable, premium volume limit, appointment or
22 cancellation of agents, claims settlement,
23 underwriting, and reinsurance. The board may
24 promulgate rules providing requirements for contracts
25 with managing general agents.

26 (b) A contract with a managing general agent and
27 reports and records submitted pursuant to those
28 contracts are subject to review by the commissioner at
29 any time pursuant to Article 1.24, Insurance Code.

30 Revisor's Note

31 (1) Section 3A(a), V.T.I.C. Article 21.07-3,
32 refers to a "valid written contract." The revised law
33 omits the reference to "valid" as unnecessary. A
34 document that does not meet the legal requirements of a
35 contract is not considered a contract.

36 (2) Section 3A(b), V.T.I.C. Article 21.07-3,
37 provides that the commissioner of insurance may review
38 certain contracts, reports, and records "at any time."
39 The revised law omits the reference to "at any time" as
40 unnecessary. In the absence of any express
41 limitation, the authority to review the contracts,

1 reports, and records includes the authority to conduct
2 the review at any time.

3 Revised Law

4 Sec. 4053.103. ACCOUNT REPORT. (a) At least once each
5 calendar quarter, a managing general agent shall submit an account
6 report to each insurer with whom the agent has a contract.

7 (b) The account report must include, as applicable, a
8 statement of:

- 9 (1) written, earned, and unearned premiums;
10 (2) losses and loss expenses paid and outstanding;
11 (3) losses incurred but not reported; and
12 (4) management fees. (V.T.I.C. Art. 21.07-3, Sec.
13 3C(a).)

14 Source Law

15 Sec. 3C. (a) A managing general agent shall
16 submit an account report to each company with which it
17 has a contract not less frequently than every calendar
18 quarter and must include in that account report, if
19 applicable, a statement of written, earned, and
20 unearned premiums, losses and loss expenses paid and
21 outstanding, losses incurred but not reported, and
22 management fees.

23 Revised Law

24 Sec. 4053.104. SEPARATE RECORDS. (a) For each insurer
25 with which a managing general agent has a contract, the agent shall
26 maintain separate records of the business handled by the agent for
27 the insurer.

28 (b) The managing general agent shall make a record required
29 under Subsection (a) available for inspection by:

- 30 (1) each insurer; and
31 (2) the department's examiners. (V.T.I.C. Art.
32 21.07-3, Sec. 3C(b).)

33 Source Law

34 (b) A managing general agent shall maintain
35 separate records of business handled by the managing
36 general agent for each company with which it has a
37 contract, and those records must be available for
38 inspection by each company and by the board's
39 examiners.

1 Revised Law

2 Sec. 4053.105. ESCROW ACCOUNT. (a) A managing general
3 agent shall maintain an escrow account in a bank that:

4 (1) is a member of the Federal Reserve System; and

5 (2) has its accounts insured by the Federal Deposit
6 Insurance Corporation.

7 (b) On receipt, the managing general agent shall deposit in
8 the escrow account all money collected for each insurer with which
9 the agent has a contract.

10 (c) Except as provided by the contract required by Section
11 4053.102, a managing general agent may not use, take as an offset,
12 or convert money that is or should have been deposited in the escrow
13 account. (V.T.I.C. Art. 21.07-3, Secs. 3C(c), (d).)

14 Source Law

15 (c) A managing general agent shall have and
16 maintain an escrow account and shall, upon receipt,
17 deposit in the escrow account all money collected for
18 all companies with which the managing general agent
19 has contracts required under Section 3A of this Act.
20 The escrow account must be maintained in a bank that is
21 a member of the Federal Reserve System and whose
22 accounts are insured by the Federal Deposit Insurance
23 Corporation.

24 (d) A managing general agent may not use, take
25 as an offset, or convert money that is deposited or
26 should have been deposited in the escrow account,
27 except as provided in a contract required by Section 3A
28 of this Act.

29 Revised Law

30 Sec. 4053.106. FIDUCIARY CAPACITY. A managing general
31 agent holds money on behalf of an insured or insurer in a fiduciary
32 capacity and shall properly account for that money as required by
33 law, department rules, and a contract with an insurer. The
34 department's examiners may audit money held in a fiduciary
35 capacity. (V.T.I.C. Art. 21.07-3, Sec. 3C(e).)

36 Source Law

37 (e) Funds held by a managing general agent on
38 behalf of insureds or a company are held in a fiduciary
39 capacity and are subject to audit by the board's
40 examiners at any time. A managing general agent must
41 properly account for all funds held in a fiduciary
42 capacity as required by law, rules of the board, and
43 any contract with a company.

1 Revisor's Note

2 (1) Section 3C(e), V.T.I.C. Article 21.07-3,
3 refers to "funds" held by a managing general agent.
4 Throughout this chapter, the revised law substitutes
5 "money" for "funds" because, in context, the terms are
6 synonymous and the former is more commonly used.

7 (2) Section 3C(e), V.T.I.C. Article 21.07-3,
8 provides that certain funds held by a managing general
9 agent are subject to audit "at any time." The revised
10 law omits the reference to "at any time" for the reason
11 stated in Revisor's Note (2) to Section 4053.102.

12 Revised Law

13 Sec. 4053.107. FINANCIAL EXAMINATION. (a) As the
14 commissioner considers necessary, a managing general agent shall
15 submit to an examination of the agent's financial condition and the
16 agent's compliance with the laws of this state affecting the
17 conduct of the agent's business.

18 (b) The examination may be conducted by:

19 (1) the commissioner;

20 (2) one or more commissioned examiners; or

21 (3) a certified public accountant or other person or
22 firm qualified to perform those examinations.

23 (c) The managing general agent shall pay the examination
24 expenses in an amount the commissioner certifies as just and
25 reasonable. (V.T.I.C. Art. 21.07-3, Sec. 3C(f).)

26 Source Law

27 (f) A managing general agent shall submit to an
28 examination of its financial condition, and its
29 compliance with the laws of Texas affecting the
30 conduct of its business by the commissioner, by one or
31 more commissioned examiners, or by a certified public
32 accountant or persons or firms qualified to perform
33 such examinations, as the commissioner deems
34 necessary. The expense of such examination shall be
35 paid by the managing general agent examined in an
36 amount the commissioner shall certify to be just and
37 reasonable.

38 Revised Law

39 Sec. 4053.108. REQUIRED NOTICES TO DEPARTMENT. (a) On

1 forms prescribed by the department, a managing general agent shall
2 notify the department not later than the 30th day after the date any
3 of the following occurs:

4 (1) balances due to an insurer for more than 90 days
5 exceed:

6 (A) \$1 million; or

7 (B) 10 percent of the insurer's policyholder
8 surplus, as reported in the annual statement filed with the
9 department;

10 (2) balances due for more than 60 days from a property
11 and casualty agent or managing general agent appointed by or
12 reporting to the managing general agent exceed \$500,000;

13 (3) authority to settle claims for an insurer is
14 withdrawn;

15 (4) money held for an insurer for losses is greater
16 than an amount that is \$100,000 more than the amount necessary to
17 pay the losses and loss adjustment expenses expected to be paid on
18 the insurer's behalf within the next 60-day period; or

19 (5) the contract required under Section 4053.102 is
20 canceled or terminated.

21 (b) Notwithstanding the time limitation imposed by
22 Subsection (a), the requirement to file under Subsections (a)(1),
23 (2), and (4) may be met with a single annual report if:

24 (1) the managing general agent routinely operates
25 above the limits established by those subsections; and

26 (2) the department verifies that fact in accordance
27 with rules adopted by the commissioner. (V.T.I.C. Art. 21.07-3,
28 Sec. 11A.)

29 Source Law

30 Sec. 11A. (a) A managing general agent licensed
31 under this Act shall notify the board on forms
32 promulgated by the board not later than the 30th day
33 after the date on which any of the following
34 circumstances occurs:

35 (1) balances due to a company or carrier
36 more than 90 days exceed \$1 million or 10 percent of
37 the company's policyholder surplus as reported in the
38 annual statement filed with the board;

1 (2) balances due more than 60 days from a
2 local recording agent or managing general agent,
3 appointed by or reporting to the managing general
4 agent exceed \$500,000;

5 (3) authority to settle claims for a
6 company is withdrawn;

7 (4) funds held for a company or carrier for
8 losses are greater than \$100,000 more than the amount
9 necessary to pay losses and loss adjustment expenses
10 expected to be paid on behalf of the company or carrier
11 within the next 60-day period; or

12 (5) the contract required under Section 3A
13 of this Act is cancelled or terminated.

14 (b) Notwithstanding the time limitation
15 provided by Subsection (a) of this section, the
16 requirement to file under Subsections (a)(1), (2), and
17 (4) of this section may be met with a single annual
18 report if the reporting person or entity routinely
19 operates above the limits provided by those
20 subdivisions and the commissioner verifies that fact
21 under rules adopted by the board.

22 Revisor's Note

23 Section 11A(a), V.T.I.C. Article 21.07-3, refers
24 to a managing general agent "licensed under this Act."
25 The revised law omits the reference to "licensed" as
26 unnecessary because Section 3, V.T.I.C. Article
27 21.07-3, revised as Section 4053.051, provides that a
28 person may not act as a managing general agent unless
29 the person is licensed under this chapter.

30 Revised Law

31 Sec. 4053.109. REINSURANCE. (a) A managing general agent
32 may not knowingly cede, arrange, facilitate, or bind an insurer to
33 reinsurance.

34 (b) Notwithstanding Subsection (a), a managing general
35 agent may bind a facultative reinsurance contract in accordance
36 with an obligatory facultative agreement if the contract with the
37 insurer contains reinsurance underwriting guidelines including,
38 for both assumed and ceded reinsurance:

39 (1) a list of reinsurers with whom the automatic
40 agreements are in effect;

41 (2) the coverages and amounts or percentages that may
42 be reinsured; and

43 (3) commission schedules.

44 (c) A managing general agent may not commit an insurer to

1 participate in insurance or reinsurance syndicates. (V.T.I.C. Art.
2 21.07-3, Sec. 3B.)

3 Source Law

4 Sec. 3B. In addition to any other conduct or
5 practice prohibited by law, a managing general agent
6 may not knowingly cede, arrange, facilitate, or bind
7 an insurer to reinsurance, except that the managing
8 general agent may bind facultative reinsurance
9 contracts pursuant to obligatory facultative
10 agreements if the contract with the insurer contains
11 reinsurance underwriting guidelines including, for
12 both reinsurance assumed and ceded, a list of
13 reinsurers with which such automatic agreements are in
14 effect, the coverages and amounts or percentages that
15 may be reinsured, and commission schedules. The
16 managing general agent may not commit the insurer to
17 participate in insurance or reinsurance syndicates.

18 Revisor's Note

19 Section 3B, V.T.I.C. Article 21.07-3, contains an
20 introductory provision that prohibits a managing
21 general agent from engaging in "any other conduct or
22 practice prohibited by law." The revised law omits the
23 provision as unnecessary because another law that
24 prohibits conduct or a practice is sufficient
25 authority for that prohibition.

26 Revised Law

27 Sec. 4053.110. REDEMPTION OF CORPORATE SHARES. A
28 corporation acting as a managing general agent may redeem the
29 shares of a shareholder or a deceased shareholder:

30 (1) on terms agreed on by the board of directors and
31 the shareholder or the shareholder's personal representative; or

32 (2) at a price and on terms provided in the articles of
33 incorporation, the bylaws, or an existing contract entered into
34 between the shareholders. (V.T.I.C. Art. 21.07-3, Sec. 4.)

35 Source Law

36 Sec. 4. A corporation may redeem the shares of
37 any shareholder or the shares of a deceased
38 shareholder, on terms agreed on by the board of
39 directors and the shareholder or the shareholder's
40 personal representative or at a price and on terms
41 provided in the articles of incorporation, the bylaws,
42 or an existing contract entered into between the
43 shareholders of the corporation.

44 [Sections 4053.111-4053.150 reserved for expansion]

1 SUBCHAPTER D. ENFORCEMENT

2 Revised Law

3 Sec. 4053.151. DISCIPLINARY ACTION. A person, firm, or
4 corporation that violates this chapter or a rule or order adopted
5 under this title, including this chapter, is subject to:

- 6 (1) Subchapters B and C, Chapter 4005; and
7 (2) Chapter 82. (V.T.I.C. Art. 21.07-3, Sec. 19(b).)

8 Source Law

9 (b) Any person, firm, or corporation who
10 violates any of the provisions of this Act or any rule
11 or order adopted under this Act or Subchapter A,
12 Chapter 21, Insurance Code, is subject to:

- 13 (1) Sections 2A, 3A, 4A, 5A, and 6A,
14 Article 21.01-2, Insurance Code; and
15 (2) Chapter 82, Insurance Code.

16 Revised Law

17 Sec. 4053.152. GUARANTY FUND REIMBURSEMENT. (a) If a
18 court finds by a final nonappealable judgment that a violation of
19 this chapter by a managing general agent contributes materially to
20 the insolvency of an insurer under which the agent held an
21 appointment, the agent shall reimburse the appropriate guaranty
22 fund for money paid to cover losses of the insolvent insurer in an
23 amount equal to all payments made from that guaranty fund in excess
24 of:

- 25 (1) gross earned premiums and investment income earned
26 on those premiums; and
27 (2) loss reserves for that business.

28 (b) The reimbursement made under this section shall be used
29 for losses, loss adjustments, and administrative expenses on
30 business placed by the managing general agent. (V.T.I.C. Art.
31 21.07-3, Sec. 19A.)

32 Source Law

33 Sec. 19A. If a court of competent jurisdiction
34 by a final nonappealable judgment determines that a
35 violation of this Act contributes materially to the
36 insolvency of an insurer under which the managing
37 general agent held an appointment, the managing
38 general agent who violated this Act shall reimburse
39 the appropriate guaranty fund for money that was paid
40 to cover losses of the insolvent insurer in an amount
41 equal to all payments made from that fund in excess of

1 gross earned premiums, and investment income earned on
2 those premiums, and loss reserves for that business.
3 The reimbursement shall be used for losses, loss
4 adjustments, and administrative expenses on business
5 placed by the managing general agent.

6 Revisor's Note

7 Section 19A, V.T.I.C. Article 21.07-3, refers to
8 a court "of competent jurisdiction." The revised law
9 omits the quoted language as unnecessary because the
10 general laws of civil jurisdiction determine which
11 courts have jurisdiction over the matter. For
12 example, see Sections 24.007-24.011, Government Code,
13 for the general jurisdiction of district courts.

14 Revisor's Note
15 (End of Chapter)

16 (1) Section 18, V.T.I.C. Article 21.07-3,
17 repeals all laws relating to the business of insurance
18 in conflict with the statute. The revised law omits
19 this provision as unnecessary because, under general
20 rules of statutory construction, a statute
21 automatically has the effect of repealing prior
22 conflicting enactments. The provision is ineffective
23 to repeal subsequent legislation. The omitted law
24 reads:

25 Sec. 18. All laws or parts of laws
26 pertaining to any phase of the insurance
27 business, which are in conflict with this
28 Act, shall be and the same are hereby
29 repealed;

30 (2) Section 18, V.T.I.C. Article 21.07-3,
31 provides for the cumulative effect of that article.
32 The revised law omits the statement as unnecessary. An
33 accepted general principle of statutory construction
34 requires a statute to be given cumulative effect with
35 other statutes unless it provides otherwise or unless
36 the statutes are in conflict. The general principle
37 applies to this revision. The omitted law reads:

38 Sec. 18. . . . but all laws, civil
39 and criminal, affecting insurance agents,
40 insurance companies or insurance carriers

1 or the insurance business, which are not in
2 conflict herewith, shall not be affected by
3 the provisions of this Act; but this Act
4 shall be deemed cumulative of such laws.

5 CHAPTER 4054. LIFE, ACCIDENT, AND HEALTH AGENTS

6 SUBCHAPTER A. GENERAL PROVISIONS

7 Sec. 4054.001. APPLICABILITY OF CHAPTER 1843

8 [Sections 4054.002-4054.050 reserved for expansion]

9 SUBCHAPTER B. GENERAL LIFE, ACCIDENT, AND HEALTH LICENSE

10 Sec. 4054.051. LICENSE REQUIRED. 1844

11 Sec. 4054.052. COMBINATION LIFE INSURANCE AGENT 1846

12 Sec. 4054.053. AUTHORITY TO WRITE ADDITIONAL LINES 1846

13 [Sections 4054.054-4054.100 reserved for expansion]

14 SUBCHAPTER C. LIMITED LIFE, ACCIDENT, AND HEALTH LICENSE

15 Sec. 4054.101. LICENSE REQUIRED. 1847

16 Sec. 4054.102. DESIGNATION OF KINDS OF INSURANCE 1848

17 Sec. 4054.103. TEMPORARY LICENSE 1848

18 [Sections 4054.104-4054.150 reserved for expansion]

19 SUBCHAPTER D. FUNERAL PREARRANGEMENT LIFE INSURANCE LICENSE

20 Sec. 4054.151. FUNERAL PREARRANGEMENT LIFE INSURANCE
21 AGENT 1848

22 Sec. 4054.152. LICENSE ISSUANCE. 1849

23 Sec. 4054.153. COURSE 1850

24 Sec. 4054.154. EXAMINATION 1850

25 Sec. 4054.155. INVESTIGATION BY DEPARTMENT 1851

26 Sec. 4054.156. WITHDRAWAL OF INSURER'S AUTHORITY 1851

27 Sec. 4054.157. LIMIT ON AGENT'S AUTHORITY 1852

28 Sec. 4054.158. REVOCATION; NOTIFICATION 1853

29 Sec. 4054.159. CONTINUING EDUCATION EXEMPTION 1853

30 Sec. 4054.160. APPLICABILITY OF LIMITED LICENSE LAWS. 1854

31 [Sections 4054.161-4054.200 reserved for expansion]

32 SUBCHAPTER E. LIFE INSURANCE NOT EXCEEDING \$15,000

33 Sec. 4054.201. LICENSE ISSUANCE; EXCEPTION 1854

34 Sec. 4054.202. COURSE 1855

35 Sec. 4054.203. EXAMINATION 1856

36 Sec. 4054.204. INVESTIGATION BY DEPARTMENT 1856

1 Sec. 4054.205. WITHDRAWAL OF INSURER'S AUTHORITY 1856
 2 Sec. 4054.206. LIMIT ON AGENT'S AUTHORITY 1857
 3 Sec. 4054.207. CONTINUING EDUCATION EXEMPTION 1857
 4 Sec. 4054.208. APPLICABILITY OF LIMITED LICENSE LAWS. 1858

5 [Sections 4054.209-4054.250 reserved for expansion]

6 SUBCHAPTER F. RENEWAL OR SERVICE COMMISSIONS TO AGENTS OF LIFE
 7 INSURANCE COMPANIES DISCONTINUING BUSINESS IN STATE

8 Sec. 4054.251. INSURANCE COMPANY LIABILITY FOR PAYMENT OF
 9 COMMISSIONS 1858
 10 Sec. 4054.252. MONTHLY AND QUARTERLY STATEMENTS 1859
 11 Sec. 4054.253. PRESUMPTION IN LAWSUIT 1859

12 CHAPTER 4054. LIFE, ACCIDENT, AND HEALTH AGENTS

13 SUBCHAPTER A. GENERAL PROVISIONS

14 Revised Law

15 Sec. 4054.001. APPLICABILITY OF CHAPTER. (a) This chapter
 16 applies to each agent of an insurer authorized to provide life,
 17 accident, and health insurance coverage in this state.

18 (b) This chapter applies to each person who:

19 (1) performs the acts of an agent, as described by
 20 Section 4001.051, whether through an oral, written, electronic, or
 21 other form of communication by soliciting, negotiating, procuring,
 22 or collecting a premium on an insurance or annuity contract offered
 23 by any type of insurer authorized to engage in the business of life,
 24 accident, and health insurance in this state; or

25 (2) represents or purports to represent a health
 26 maintenance organization in soliciting, negotiating, procuring, or
 27 effecting membership in the health maintenance organization.

28 (V.T.I.C. Art. 21.07-1, Sec. 1(b).)

29 Source Law

30 (b) Each agent of an insurance company
 31 authorized to provide life, accident, and health
 32 insurance coverage in this state is subject to this
 33 article. This article applies to each person who:

34 (1) performs the acts of an agent, as
 35 defined by Article 21.02 of this code, whether through
 36 oral, written, or electronic communications or
 37 otherwise, by the solicitation of, negotiation for,
 38 procurement of, or collection of premiums on an

1 insurance or annuity contract offered by any type of
2 insurance carrier authorized to sell life, accident,
3 and health insurance products in this state; or
4 (2) represents or purports to represent a
5 health maintenance organization in the solicitation,
6 negotiation, procurement, or effectuation of
7 membership in the health maintenance organization.

8 Revisor's Note
9 (End of Subchapter)

10 Section 1(a), V.T.I.C. Article 21.07-1, provides
11 that the article may be cited as the "Texas Life,
12 Accident, and Health Agents License Act." The revised
13 law omits this provision because the logical
14 arrangement of this chapter includes the revision of
15 V.T.I.C. Article 21.08 and the short title cannot
16 properly be applied to that article. The omitted law
17 reads:

18 Art. 21.07-1
19 Sec. 1. (a) This article may be
20 cited as the Texas Life, Accident, and
21 Health Agents License Act.

22 [Sections 4054.002-4054.050 reserved for expansion]

23 SUBCHAPTER B. GENERAL LIFE, ACCIDENT, AND HEALTH LICENSE

24 Revised Law

25 Sec. 4054.051. LICENSE REQUIRED. A person is required to
26 hold a general life, accident, and health license if the person acts
27 as:

28 (1) an agent who represents a health maintenance
29 organization;

30 (2) an industrial life insurance agent for an insurer
31 that writes only weekly premium life insurance on a debit basis
32 under Chapter 1151;

33 (3) an agent who writes life, accident, and health
34 insurance for a life insurance company;

35 (4) an agent who writes only accident and health
36 insurance;

37 (5) an agent who writes fixed or variable annuity
38 contracts or variable life contracts;

39 (6) an agent who writes for a stipulated premium

1 company:

2 (A) only life insurance in excess of \$15,000 on
3 any one life;

4 (B) only accident and health insurance; or

5 (C) both kinds of insurance described by
6 Paragraphs (A) and (B);

7 (7) an agent who writes life, accident, and health
8 insurance for any type of authorized life insurance company that is
9 domiciled in this state, including a legal reserve life insurance
10 company, and who represents the company:

11 (A) in a foreign country or territory; and

12 (B) on a United States military installation or
13 with United States military personnel;

14 (8) an agent who writes life, accident, and health
15 insurance for a fraternal benefit society except as provided by
16 Section 885.352; or

17 (9) an agent who writes any other kind of insurance as
18 required by the commissioner for the protection of the insurance
19 consumers of this state. (V.T.I.C. Art. 21.07-1, Sec. 2(a).)

20 Source Law

21 Sec. 2. (a) A general life, accident, and
22 health license is required for each person who acts as:

23 (1) an agent writing life, accident, and
24 health insurance for a life insurance company;

25 (2) an agent writing only accident and
26 health insurance;

27 (3) an agent representing a health
28 maintenance organization;

29 (4) an agent writing fixed or variable
30 annuity contracts or variable life contracts;

31 (5) an industrial life insurance agent for
32 an industrial company that writes only weekly premium
33 life insurance on a debit basis under Article 3.52 of
34 this code;

35 (6) an agent writing:

36 (A) only life insurance in excess of
37 \$15,000 on any one life for a stipulated premium
38 insurance company;

39 (B) only accident and health
40 insurance for a stipulated premium insurance company;
41 or

42 (C) both types of insurance described
43 by Paragraphs (A) and (B) of this subdivision;

44 (7) an agent writing life, accident, and
45 health insurance for any type of authorized life
46 insurance company, including a legal reserve life
47 insurance company, domiciled in this state,

1 representing the insurer in a foreign country or
2 territory and either on a United States military
3 installation or with United States military personnel;
4 (8) an agent writing life, accident, and
5 health insurance for a fraternal benefit society
6 except as provided by Article 10.37-3 of this code; or
7 (9) an agent writing any other type of
8 insurance as required by the commissioner for the
9 protection of the insurance consumers of this state.

10 Revisor's Note

11 Section 2(a)(5), V.T.I.C. Article 21.07-1,
12 refers to an "industrial company" that writes a
13 specific type of industrial life insurance. This code
14 does not substantively distinguish between an insurer
15 that writes industrial life insurance and an
16 "industrial" insurer that writes industrial life
17 insurance. The revised law therefore substitutes
18 "insurer" for "industrial company" to conform to the
19 terminology used throughout this code.

20 Revised Law

21 Sec. 4054.052. COMBINATION LIFE INSURANCE AGENT. (a) In
22 this section, a "combination company" means an insurer that writes
23 weekly premium life insurance or monthly ordinary life insurance on
24 a debit basis.

25 (b) A person may not act as a combination life insurance
26 agent for a combination company unless the person holds a general
27 life, accident, and health license.

28 (c) A combination company and a combination life insurance
29 agent may also write ordinary life insurance contracts. (V.T.I.C.
30 Art. 21.07-1, Sec. 2(b).)

31 Source Law

32 (b) For the purposes of this subsection, a
33 "combination company" is an insurer that writes weekly
34 premium life insurance or monthly ordinary life
35 insurance on a debit basis. A general life, accident,
36 and health license is required for each person who acts
37 as a combination life insurance agent for a
38 combination company. A combination company and a
39 combination life insurance agent may also write
40 ordinary contracts of life insurance.

41 Revised Law

42 Sec. 4054.053. AUTHORITY TO WRITE ADDITIONAL LINES. A

1 person who holds a general life, accident, and health license may,
2 without obtaining an additional license, write the kinds of
3 insurance contracts described by:

- 4 (1) Subchapter C, D, or E; or
- 5 (2) Chapter 4055. (V.T.I.C. Art. 21.07-1, Sec. 3.)

6 Source Law

7 Sec. 3. A person who holds a general life,
8 accident, and health license issued under the
9 requirements of this subchapter may, without obtaining
10 an additional license, write additional types of
11 insurance contracts as provided under:

- 12 (1) Sections 4, 5, and 6 of this article;
- 13 or
- 14 (2) Article 21.09 of this code.

15 [Sections 4054.054-4054.100 reserved for expansion]

16 SUBCHAPTER C. LIMITED LIFE, ACCIDENT, AND HEALTH LICENSE

17 Revised Law

18 Sec. 4054.101. LICENSE REQUIRED. Except as provided by
19 Section 4054.053, an agent is required to hold a limited life,
20 accident, and health license if the agent writes:

- 21 (1) a policy or rider to a policy that provides only:

- 22 (A) lump-sum cash benefits in the event of
23 accidental death or dismemberment; or

- 24 (B) ambulance expense benefits in the event of
25 accident or sickness;

- 26 (2) a prepaid legal services contract under Article
27 5.13-1 or Chapter 961;

- 28 (3) credit insurance, except as otherwise provided by
29 Chapter 4055; or

- 30 (4) any other kind of insurance, if holding a limited
31 life, accident, and health license to write that kind of insurance
32 is determined necessary by the commissioner for the protection of
33 the insurance consumers of this state. (V.T.I.C. Art. 21.07-1,
34 Sec. 4(a).)

35 Source Law

36 Sec. 4. (a) An agent must hold a limited life,
37 accident, and health license if the agent writes:

- 38 (1) a policy or rider to a policy that
39 provides only:

1 (A) lump-sum cash benefits in the
2 event of accidental death, death by accidental means,
3 or dismemberment; or

4 (B) ambulance expense benefits in the
5 event of accident or sickness;

6 (2) a prepaid legal services contract
7 under Article 5.13-1 or Chapter 23 of this code;

8 (3) credit insurance except as otherwise
9 provided under Article 21.09 of this code; or

10 (4) any other type of insurance, if
11 determined necessary by the commissioner to protect
12 insurance consumers in this state.

13 Revisor's Note

14 Section 4(a)(1)(A), V.T.I.C. Article 21.07-1,
15 refers to "accidental death" and "death by accidental
16 means." The revised law omits "death by accidental
17 means" because the meaning of that phrase is included
18 in the meaning of "accidental death."

19 Revised Law

20 Sec. 4054.102. DESIGNATION OF KINDS OF INSURANCE. A person
21 who holds a limited life, accident, and health license may write
22 only the kind of insurance designated on the license. (V.T.I.C.
23 Art. 21.07-1, Sec. 4(b).)

24 Source Law

25 (b) A person who holds a limited life, accident,
26 and health license issued under this section may write
27 only the types of insurance products designated on the
28 license by the department.

29 Revised Law

30 Sec. 4054.103. TEMPORARY LICENSE. An applicant for a
31 limited life, accident, and health license is eligible for a
32 temporary license under Subchapter D, Chapter 4001. (V.T.I.C.
33 Art. 21.07-1, Sec. 4(c).)

34 Source Law

35 (c) An applicant for a limited life, accident,
36 and health license is eligible for a temporary license
37 under Section 3A, Article 21.07, of this code.

38 [Sections 4054.104-4054.150 reserved for expansion]

39 SUBCHAPTER D. FUNERAL PREARRANGEMENT LIFE INSURANCE LICENSE

40 Revised Law

41 Sec. 4054.151. FUNERAL PREARRANGEMENT LIFE INSURANCE
42 AGENT. A funeral prearrangement life insurance agent is a life

1 insurance agent who, subject to the limitations of this subchapter,
2 writes only life insurance policies and fixed annuity contracts to
3 secure the delivery of funeral services and merchandise under
4 prepaid funeral contracts regulated by the Texas Department of
5 Banking under Chapter 154, Finance Code. (V.T.I.C. Art. 21.07-1,
6 Sec. 5(a).)

7 Source Law

8 Sec. 5. (a) In this section, "funeral
9 prearrangement life insurance agent" means a life
10 insurance agent who, subject to the limitations of
11 this section, writes only life insurance policies and
12 fixed annuity contracts to secure the delivery of
13 funeral services and merchandise under prepaid funeral
14 contracts regulated by the Texas Department of Banking
15 under Chapter 154, Finance Code.

16 Revised Law

17 Sec. 4054.152. LICENSE ISSUANCE. The department shall
18 issue a license to an individual applicant to act as a funeral
19 prearrangement life insurance agent on receipt of certification
20 from an insurer authorized to write life insurance policies and
21 fixed annuity contracts in this state that the applicant has:

22 (1) completed a course of study and instruction in
23 compliance with this subchapter; and

24 (2) passed without aid a written examination
25 administered by the insurer. (V.T.I.C. Art. 21.07-1, Sec. 5(b)
26 (part).)

27 Source Law

28 (b) The department shall issue a license to act
29 as a funeral prearrangement life insurance agent to an
30 individual after receiving certification from an
31 insurance company authorized to write life insurance
32 and annuities in this state that the applicant has
33 completed a course of study and instruction [on life
34 insurance and fixed annuities for applicants offered
35 by the insurance company] and passed without aid a
36 written examination administered by the insurance
37 company. . . .

38 Revisor's Note

39 Section 5(b), V.T.I.C. Article 21.07-1, refers to
40 an insurer authorized to write "life insurance and
41 annuities" in this state. The revised law substitutes
42 "life insurance policies and fixed annuity contracts"

1 for the quoted language for consistency with the
2 language of Section 5(a), V.T.I.C. Article 21.07-1,
3 revised in this chapter as Section 4054.151.

4 Revised Law

5 Sec. 4054.153. COURSE. (a) To be eligible to receive a
6 license under this subchapter, an applicant must complete a course
7 of study and instruction offered by an insurer under this section on
8 life insurance policies and fixed annuity contracts.

9 (b) The course of study and instruction must:

10 (1) be at least five hours in duration; and

11 (2) include instruction on:

12 (A) the life insurance policies and fixed annuity
13 contracts to be sold; and

14 (B) the laws relating to funeral prearrangement.

15 (V.T.I.C. Art. 21.07-1, Sec. 5(b) (part).)

16 Source Law

17 (b) . . . [that the applicant has completed a
18 course of study and instruction] on life insurance and
19 fixed annuities for applicants offered by the
20 insurance company The course of study and
21 instruction must be at least a five-hour course and
22 must include instruction on:

23 (1) the policies to be sold; and

24 (2) the laws relating to funeral
25 prearrangement.

26 Revisor's Note

27 Section 5(b), V.T.I.C. Article 21.07-1, refers to
28 a course of study and instruction on "life insurance
29 and fixed annuities" and provides that the course must
30 include instruction on "the policies to be sold." To
31 provide consistent terminology in this subchapter, the
32 revised law refers to a course on "life insurance
33 policies and fixed annuity contracts" and provides
34 that the course must include instruction on "the life
35 insurance policies and fixed annuity contracts to be
36 sold."

37 Revised Law

38 Sec. 4054.154. EXAMINATION. (a) The commissioner shall

1 prescribe a uniform examination for applicants that fairly tests
2 knowledge of the information contained in the course under Section
3 4054.153.

4 (b) The department shall authorize an insurer to administer
5 the examination as provided by this section after approval by the
6 department of a complete outline and explanation of the course and
7 the manner of conducting the examination. (V.T.I.C. Art. 21.07-1,
8 Sec. 5(c).)

9 Source Law

10 (c) The commissioner shall authorize an
11 insurance company to administer a funeral
12 prearrangement life insurance agent examination as
13 provided by Subsection (b) of this section after
14 approval by the commissioner of a complete outline and
15 explanation of the course of study and instruction and
16 the nature and manner of conducting the examination
17 for applicants. The commissioner shall prescribe a
18 uniform examination for applicants that fairly
19 addresses the information contained in the approved
20 course of study and instruction.

21 Revisor's Note

22 Section 5(c), V.T.I.C. Article 21.07-1, refers to
23 the "nature and manner" of conducting an examination.
24 Throughout this chapter, the revised law omits the
25 reference to "nature" because, in context, "nature" is
26 included in the meaning of "manner."

27 Revised Law

28 Sec. 4054.155. INVESTIGATION BY DEPARTMENT. The
29 department may investigate as necessary the manner of instruction
30 and the examination administered by an insurer under this
31 subchapter. (V.T.I.C. Art. 21.07-1, Sec. 5(d) (part).)

32 Source Law

33 (d) The commissioner may investigate as
34 necessary the manner of instruction and the
35 examination administered by an insurance company under
36 this section. . . .

37 Revised Law

38 Sec. 4054.156. WITHDRAWAL OF INSURER'S AUTHORITY. The
39 department may withdraw from an insurer the authority under this
40 subchapter to offer instruction and administer an examination.

1 (V.T.I.C. Art. 21.07-1, Sec. 5(d) (part).)

2 Source Law

3 (d) . . . The commissioner may withdraw from
4 an insurance company the authority under this section
5 to offer instruction and administer an examination.

6 Revised Law

7 Sec. 4054.157. LIMIT ON AGENT'S AUTHORITY. A funeral
8 prearrangement life insurance agent licensed under this subchapter
9 may not write any coverage or combination of coverages with an
10 initial guaranteed death benefit that exceeds \$15,000 on any life.

11 (V.T.I.C. Art. 21.07-1, Sec. 5(e) (part).)

12 Source Law

13 (e) A funeral prearrangement life insurance
14 agent licensed under this section may not:

15 (1) write any coverage or combination of
16 coverages with an initial guaranteed death benefit
17 that exceeds \$15,000 on any life; or

18 . . .

19 Revisor's Note

20 Section 5(e), V.T.I.C. Article 21.07-1, states
21 that a funeral prearrangement life insurance agent may
22 not act as an agent for more than one insurer.
23 However, Section 5B, V.T.I.C. Article 21.07-1, revised
24 in relevant part in this chapter as Section 4054.159,
25 states that the agent may be appointed by more than one
26 insurer. Section 5(e) was added by Chapter 703, Acts
27 of the 77th Legislature, Regular Session, 2001. The
28 last legislative vote on Chapter 703 occurred on May
29 18, 2001. Section 5B was added by Chapter 699, Acts of
30 the 77th Legislature, Regular Session, 2001. The last
31 legislative vote on Chapter 699 occurred on May 24,
32 2001. Under Section 312.014(a), Government Code, if a
33 statute is irreconcilable with another statute enacted
34 at the same session of a legislature, the statute
35 latest in date of enactment prevails. Under Section
36 312.014(d), Government Code, the date of enactment is
37 the date on which the last legislative vote is taken on

1 the bill enacting the statute. The revised law is
2 drafted accordingly. The omitted law reads:

3 [(e) A funeral prearrangement life
4 insurance agent licensed under this section
5 may not:]

6 (2) act as an agent for more
7 than one insurance company.
8

9 Revised Law

10 Sec. 4054.158. REVOCATION; NOTIFICATION. (a) A license
11 issued under this subchapter to act as an agent for an insurer is
12 revoked if the license holder ceases to act as an agent for the
13 insurer.

14 (b) Not later than the 15th day after the date on which the
15 license holder ceases to act as an agent for an insurer, the insurer
16 or agent shall send written notification to the department.
17 (V.T.I.C. Art. 21.07-1, Sec. 5(f).)

18 Source Law

19 (f) A license issued under this section to act
20 as an agent for an insurance company is canceled when
21 the license holder ceases to act as an agent for an
22 insurance company. Not later than the 15th day after
23 the date on which the license holder ceases to act as
24 an agent for an insurance company, the insurance
25 company or agent shall send written notification to
26 the department.

27 Revisor's Note

28 Section 5(f), V.T.I.C. Article 21.07-1, refers to
29 a license being "canceled." The revised law
30 substitutes "revoked" for "canceled" because, in
31 context, the terms are synonymous, and "revoked" is
32 the more commonly used term.

33 Revised Law

34 Sec. 4054.159. CONTINUING EDUCATION EXEMPTION. (a)
35 Notwithstanding any other provision of this code, a funeral home
36 employee or other person who holds a funeral prearrangement life
37 insurance agent license and who writes only life insurance policies
38 and fixed annuity contracts to secure the delivery of funeral
39 services and merchandise under prepaid funeral contracts regulated
40 by the Texas Department of Banking under Chapter 154, Finance Code,

1 is not required to comply with any continuing education
2 requirements to maintain the license, except that the appointing
3 insurer must educate its appointed agents about any new products
4 sold by the agent to fund prepaid funeral contracts.

5 (b) A license holder to whom this section applies may be
6 appointed by more than one insurer. (V.T.I.C. Art. 21.07-1, Sec. 5B
7 (part).)

8 Source Law

9 Sec. 5B. Notwithstanding any other provision of
10 this code, a funeral home employee or other person who
11 has a funeral prearrangement life insurance agent
12 license . . . who writes only life insurance policies
13 and fixed annuity contracts to secure the delivery of
14 funeral services and merchandise under prepaid funeral
15 contracts regulated by the Texas Department of Banking
16 under Chapter 154, Finance Code, is not required to
17 comply with any continuing education requirements in
18 order to maintain such a license, except that the
19 appointing insurance company must educate its
20 appointed agents about any new products sold by the
21 licensed agent to fund prepaid funeral contracts.
22 Such a licensee may be appointed by more than one
23 insurance company.

24 Revised Law

25 Sec. 4054.160. APPLICABILITY OF LIMITED LICENSE
26 LAWS. Except as specifically provided by this subchapter, the
27 provisions of this title that apply to the holder of a limited
28 license apply to the holder of a license issued under this
29 subchapter. (V.T.I.C. Art. 21.07-1, Sec. 5(g).)

30 Source Law

31 (g) Except as specifically provided by this
32 section, the provisions of this subchapter that apply
33 to a limited license apply to a license issued under
34 this section.

35 [Sections 4054.161-4054.200 reserved for expansion]

36 SUBCHAPTER E. LIFE INSURANCE NOT EXCEEDING \$15,000

37 Revised Law

38 Sec. 4054.201. LICENSE ISSUANCE; EXCEPTION. (a) The
39 department shall issue a license to an individual applicant to act
40 as an agent who writes only life insurance policies in an amount
41 that does not exceed \$15,000 on any one life on receipt of
42 certification from a stipulated premium company, a statewide mutual

1 assessment company, a local mutual aid association, or a local
2 mutual burial association, that the applicant has:

3 (1) completed a course of study and instruction in
4 compliance with this subchapter; and

5 (2) passed without aid a written examination
6 administered by the insurer.

7 (b) A license is not required under this subchapter for an
8 agent who, in the preceding calendar year, wrote policies that
9 generated, in the aggregate, less than \$20,000 in direct premium.

10 (V.T.I.C. Art. 21.07-1, Secs. 6(a) (part), (e).)

11 Source Law

12 Sec. 6. (a) The department shall issue a
13 license to act as an agent to an individual who writes
14 only life insurance not to exceed \$15,000 on any one
15 life after receiving certification from a stipulated
16 premium insurance company, a statewide mutual
17 assessment company, a local mutual aid association, or
18 a local mutual burial association, that the applicant
19 has completed a course of study and instruction [on
20 life insurance and fixed annuities offered by the
21 insurer and] passed without aid a written examination
22 administered by the insurer. . . .

23 (e) A license is not required under this section
24 for an agent who, in the preceding calendar year, wrote
25 policies that generated, in the aggregate, less than
26 \$20,000 in direct premium.

27 Revised Law

28 Sec. 4054.202. COURSE. (a) To be eligible to receive a
29 license under this subchapter, an applicant must complete a course
30 of study and instruction offered by an insurer under this section on
31 life insurance and fixed annuities.

32 (b) The course of study and instruction must:

33 (1) be at least five hours in duration; and

34 (2) include instruction on:

35 (A) the policies to be sold; and

36 (B) the laws relating to the regulation of
37 insurance in this state. (V.T.I.C. Art. 21.07-1, Sec. 6(a)
38 (part).)

39 Source Law

40 Sec. 6. (a) . . . [that the applicant has
41 completed a course of study and instruction] on life

1 insurance and fixed annuities offered by the insurer
2 and The course of study and instruction must
3 be at least a five-hour course and must include
4 instruction on:

- 5 (1) the policies to be sold; and
6 (2) the laws relating to the regulation of
7 insurance in this state.

8 Revised Law

9 Sec. 4054.203. EXAMINATION. (a) The commissioner shall
10 prescribe a uniform examination for applicants that fairly tests
11 knowledge of the information contained in the course provided under
12 Section 4054.202.

13 (b) The department shall authorize an insurer described by
14 Section 4054.201 to administer the examination as provided by this
15 section after approval by the department of a complete outline and
16 explanation of the course and the manner of conducting the
17 examination. (V.T.I.C. Art. 21.07-1, Sec. 6(b).)

18 Source Law

19 (b) The commissioner shall authorize an insurer
20 described by Subsection (a) of this section to
21 administer an agent examination as provided by
22 Subsection (a) of this section after approval by the
23 commissioner of a complete outline and explanation of
24 the course of study and instruction and the nature and
25 manner of conducting the examination for applicants.
26 The commissioner shall prescribe a uniform examination
27 for applicants that fairly addresses the information
28 contained in the approved course of study and
29 instruction.

30 Revised Law

31 Sec. 4054.204. INVESTIGATION BY DEPARTMENT. The department
32 may investigate as necessary the manner of instruction and the
33 examination administered by an insurer under this subchapter.
34 (V.T.I.C. Art. 21.07-1, Sec. 6(c) (part).)

35 Source Law

36 (c) The commissioner may investigate as
37 necessary the manner of instruction and the
38 examination administered by an insurer under this
39 section. . . .

40 Revised Law

41 Sec. 4054.205. WITHDRAWAL OF INSURER'S AUTHORITY. The
42 department may withdraw from an insurer the authority under this
43 subchapter to offer instruction and administer an examination.
44 (V.T.I.C. Art. 21.07-1, Sec. 6(c) (part).)

1 appointing insurance company must educate its
2 appointed agents about any new products sold by the
3 licensed agent to fund prepaid funeral contracts.
4 Such a licensee may be appointed by more than one
5 insurance company.]

6 Revised Law

7 Sec. 4054.208. APPLICABILITY OF LIMITED LICENSE
8 LAWS. Except as specifically provided by this subchapter, the
9 provisions of this title that apply to the holder of a limited
10 license apply to the holder of a license issued under this
11 subchapter. (V.T.I.C. Art. 21.07-1, Sec. 6(f).)

12 Source Law

13 (f) Except as specifically provided by this
14 section, the provisions of this subchapter that apply
15 to a limited license apply to a license issued under
16 this section.

17 [Sections 4054.209-4054.250 reserved for expansion]

18 SUBCHAPTER F. RENEWAL OR SERVICE COMMISSIONS TO AGENTS OF LIFE
19 INSURANCE COMPANIES DISCONTINUING BUSINESS IN STATE

20 Revised Law

21 Sec. 4054.251. INSURANCE COMPANY LIABILITY FOR PAYMENT OF
22 COMMISSIONS. A life insurance company that discontinues the
23 business of issuing life insurance policies on the lives of
24 residents of this state remains liable for the payment of renewal or
25 service commissions on life insurance policies previously written
26 by the company under the terms of the company's contracts
27 previously made with agents residing in this state. (V.T.I.C. Art.
28 21.08 (part).)

29 Source Law

30 Art. 21.08. If any life insurance company now
31 engaged or which hereafter may be engaged in the
32 business of issuing policies of life insurance upon
33 the lives of citizens of this State shall discontinue
34 such business, it shall nevertheless continue to be
35 liable for the payment of renewal or service
36 commissions on policies of life insurance theretofore
37 written in accordance with the terms of its agency
38 contracts theretofore made with agents residing in the
39 State of Texas.
40 . . .

41 Revisor's Note

42 V.T.I.C. Article 21.08 refers to "citizens of
43 this State." The revised law substitutes "residents"

1 for "citizens" because, in context, the terms are
2 synonymous, and "residents" is more commonly used.

3 Revised Law

4 Sec. 4054.252. MONTHLY AND QUARTERLY STATEMENTS. (a) A
5 life insurance company shall provide to each agent who may be
6 entitled to receive renewal or service commissions from the company
7 under Section 4054.251:

8 (1) a monthly statement that shows the policies
9 written by the agent for the company that terminated during the
10 month for which the statement is made; and

11 (2) at least quarterly, a detailed statement of all
12 policies written by the agent for the company on the lives of
13 residents of this state that shows:

14 (A) the policies in force; and

15 (B) the policies that have terminated, with the
16 reason for the termination.

17 (b) A life insurance company is not required to provide an
18 agent with a statement under this section after the expiration of
19 the period during which renewal or service commissions are payable
20 as to all of the policies written by the agent for the company.
21 (V.T.I.C. Art. 21.08 (part).)

22 Source Law

23 Art. 21.08. . . .

24 Every such company shall furnish monthly to each
25 person who may be entitled to receive service or
26 renewal commissions from such company a statement
27 showing such policies written by such person for such
28 company as shall have terminated during the month for
29 which the statement is made, and shall furnish to each
30 such person not less than quarterly a detailed
31 statement of all policies written by such person for
32 such company on the lives of residents of the State of
33 Texas, showing the policies in force, the policies
34 which have terminated, and the reason for termination.
35 Provided, however, that no such statements need be
36 furnished after the period during which service or
37 renewal commissions are payable has ended as to all of
38 the policies written by such person for such company.
39 . . .

40 Revised Law

41 Sec. 4054.253. PRESUMPTION IN LAWSUIT. In a suit against a
42 life insurance company for the recovery of a renewal or service

1 commission under this subchapter, a presumption exists that each
 2 policy written by the company on the life of a resident of this
 3 state by the agent bringing the suit continues in effect unless the
 4 defendant proves the contrary by competent evidence. (V.T.I.C.
 5 Art. 21.08 (part).)

6 Source Law

7 Art. 21.08. . . .

8 In any suit against any such company for the
 9 recovery of service or renewal commissions, it shall
 10 be presumed that all policies written in such company
 11 upon the lives of residents of Texas by the person
 12 bringing such suit have continued in effect unless and
 13 until the contrary is proven by the defendant by
 14 competent evidence.

15 CHAPTER 4055. SPECIALTY AGENTS

16 SUBCHAPTER A. GENERAL PROVISIONS

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1 CHAPTER 4055. SPECIALTY AGENTS

2 SUBCHAPTER A. GENERAL PROVISIONS

3 Revised Law

4 Sec. 4055.001. DEFINITION. In this chapter, "specialty
5 license holder" means a person who holds a license issued under this
6 chapter. (V.T.I.C. Art. 21.09, Sec. 1(a) (part).)

7 Source Law

8 Art. 21.09
9 Sec. 1. (a) . . . A person who holds a license
10 under this article is known as a "specialty license
11 holder." . . .

12 Revised Law

13 Sec. 4055.002. APPLICABILITY OF CHAPTER TO CERTAIN
14 AGENTS. (a) A person who holds a general property and casualty
15 license issued under Chapter 4051 or a general life, accident, and
16 health license issued under Chapter 4054 or who holds a
17 substantially equivalent license under this code, as determined by
18 the commissioner, is not required to obtain a specialty license.

19 (b) A person described by Subsection (a) is subject to the
20 other requirements of this chapter in the solicitation, sale, or
21 delivery of an insurance product that is subject to this chapter.
22 (V.T.I.C. Art. 21.09, Sec. 1(j).)

23 Source Law

24 (j) A person who holds a general agent's license
25 issued under Chapter 213, Acts of the 54th
26 Legislature, Regular Session, 1955 (Article 21.07-1,
27 Vernon's Texas Insurance Code), as amended, or Article
28 21.14 of this code or who holds a substantially
29 equivalent license under this code, as determined by
30 the commissioner, is not required to obtain a
31 specialty license but is subject to the other
32 requirements of this article in the solicitation,
33 sale, or delivery of an insurance product subject to
34 this article.

35 Revisor's Note

36 (1) Section 1(j), V.T.I.C. Article 21.09,
37 refers to a person who holds a "general agent's
38 license" issued under V.T.I.C. Article 21.07-1 or
39 V.T.I.C. Article 21.14. Chapter 703, Acts of the 77th
40 Legislature, Regular Session, 2001, consolidated the

1 types of licenses issued to insurance agents and
2 eliminated the quoted category of agent license.
3 V.T.I.C. Article 21.07-1, as added by Article 2,
4 Chapter 703, Acts of the 77th Legislature, Regular
5 Session, 2001, requires an agent to hold a "general
6 life, accident, and health license" rather than a
7 "general agent's license." V.T.I.C. Article 21.14, as
8 amended by Article 3, Chapter 703, Acts of the 77th
9 Legislature, Regular Session, 2001, requires an agent
10 to hold a "general property and casualty license"
11 rather than a "general agent's license." The revised
12 law is drafted accordingly.

13 (2) Section 1(j), V.T.I.C. Article 21.09,
14 refers to V.T.I.C. Article 21.07-1 "as amended." The
15 revised law omits the reference to "as amended"
16 because under Section 311.027, Government Code (Code
17 Construction Act), applicable to the revised law, a
18 reference to a statute applies to all reenactments,
19 revisions, and amendments of the statute.

20 Revised Law

21 Sec. 4055.003. RULES. The commissioner may adopt rules
22 necessary to implement this chapter and to meet the minimum
23 requirements of federal law, including regulations. (V.T.I.C. Art.
24 21.09, Sec. 1(a) (part).)

25 Source Law

26 (a) . . . The commissioner may adopt rules
27 necessary to implement this article and to meet the
28 minimum requirements of federal law and regulations.

29 Revised Law

30 Sec. 4055.004. APPLICATION. To obtain a specialty license
31 an applicant must:

32 (1) submit to the commissioner:

33 (A) a written application:

34 (i) signed by the applicant;

35 (ii) on a form and supplements to the form

1 prescribed by the commissioner; and

2 (iii) containing the information
3 prescribed by the commissioner;

4 (B) a certification by an insurer authorized to
5 engage in business in this state:

6 (i) signed and sworn to by an officer of the
7 insurer;

8 (ii) stating that the insurer is satisfied
9 that the applicant is trustworthy and competent to act as the
10 insurer's agent for a limited purpose authorized by this chapter;
11 and

12 (iii) stating that if the specialty license
13 applied for is issued by the department the insurer will appoint the
14 applicant to act as an agent for a kind of insurance that is subject
15 to this chapter; and

16 (C) a nonrefundable license fee set by the
17 department in an amount necessary to administer this chapter; and

18 (2) comply with the other requirements of this
19 chapter. (V.T.I.C. Art. 21.09, Sec. 1(b).)

20 Source Law

21 (b) For a specialty license to be issued under
22 this article, the applicant must submit to the
23 commissioner:

24 (1) a written application, signed by the
25 applicant, on a form and supplements to the form
26 prescribed by the commissioner, that contains the
27 information prescribed by the commissioner;

28 (2) a certification by an insurer
29 authorized to do business in this state that:

30 (A) is signed by an officer of the
31 insurer and affirmed as true under the penalties of
32 perjury; and

33 (B) states that:

34 (i) the insurer has satisfied
35 itself that the named applicant is trustworthy and
36 competent to act as the insurer's agent for a limited
37 purpose authorized by this article; and

38 (ii) the insurer will appoint
39 the applicant to act as the agent for a type of
40 insurance permitted by this article, if the specialty
41 license applied for is issued by the department; and

42 (3) a nonrefundable license fee set by the
43 department in an amount necessary to administer this
44 article.

1 Revised Law

2 Sec. 4055.005. LICENSE ISSUANCE. The commissioner may
3 issue a specialty license to an applicant who complies with Section
4 4055.004 and the other requirements of this chapter. (V.T.I.C.
5 Art. 21.09, Sec. 1(a) (part).)

6 Source Law

7 Sec. 1. (a) The commissioner may issue a
8 specialty license to an applicant who has complied
9 with the requirements of this article. . . .

10 Revised Law

11 Sec. 4055.006. EXAMINATION AND CONTINUING EDUCATION NOT
12 REQUIRED. (a) An examination is not required for issuance of a
13 specialty license.

14 (b) A person is not required to comply with continuing
15 education requirements to hold a specialty license. (V.T.I.C. Art.
16 21.09, Sec. 1(1).)

17 Source Law

18 (1) An examination is not required for issuance
19 of a license under this article and continuing
20 education requirements do not apply to a license
21 issued under this article.

22 Revised Law

23 Sec. 4055.007. APPOINTMENT AS AGENT BY INSURER. An insurer
24 that appoints an agent under this chapter shall:

25 (1) submit a certification of the appointment signed
26 by an officer of the insurer; and

27 (2) affirm that the insurer is satisfied that the
28 specialty license holder is trustworthy and competent to act as an
29 agent on behalf of the insurer. (V.T.I.C. Art. 21.09, Sec. 1(k).)

30 Source Law

31 (k) Each insurance company appointing an agent
32 under this article shall submit a certification of the
33 appointment signed by an officer of the insurer and
34 affirm that the insurer has satisfied itself that the
35 license holder is trustworthy and competent to act as
36 an insurance agent on behalf of the insurer.

37 Revised Law

38 Sec. 4055.008. GENERAL POWERS AND DUTIES. (a) A
39 specialty license holder may act as an agent for the kinds of

1 insurance that are subject to this chapter for any insurer
2 authorized to engage in the business of those kinds of insurance in
3 this state.

4 (b) Except as otherwise provided by this chapter, a
5 specialty license holder acting under this chapter shall comply
6 with this title. (V.T.I.C. Art. 21.09, Sec. 1(a) (part), (e).)

7 Source Law

8 Sec. 1. (a) . . . A specialty license
9 authorizes the license holder to act as an agent for
10 the types of insurance specified in this article for
11 any insurer authorized to write these types of
12 insurance in this state. . . .

13 (e) Except as otherwise provided by this
14 article, a specialty license holder acting under this
15 article shall comply with all applicable provisions of
16 this subchapter.

17 Revisor's Note

18 Section 1(e), V.T.I.C. Article 21.09, states that
19 a specialty license holder acting under Article 21.09
20 shall comply with "all applicable provisions of"
21 Subchapter A, Chapter 21, Insurance Code, revised as
22 this title. The revised law omits the quoted language
23 as unnecessary because a person can only comply with
24 applicable provisions of law.

25 Revised Law

26 Sec. 4055.009. CERTAIN REPRESENTATIONS PROHIBITED. A
27 specialty license holder may not advertise, represent, or otherwise
28 hold out the license holder or an employee of the license holder as
29 an agent licensed under another chapter unless the entity or
30 individual holds the applicable license. (V.T.I.C. Art. 21.09,
31 Sec. 1(i).)

32 Source Law

33 (i) A specialty license holder may not in any
34 manner advertise, represent, or otherwise hold out the
35 license holder or any employee of the license holder as
36 a licensed insurance agent under another article of
37 this code unless the entity or individual actually
38 holds the applicable license.

39 Revised Law

40 Sec. 4055.010. TREATMENT OF CERTAIN PREMIUMS.

1 Notwithstanding any other provision of this title or any rule
2 adopted by the commissioner, a specialty license holder is not
3 required to treat as money received in a fiduciary capacity
4 premiums collected from a consumer who purchases insurance coverage
5 when completing a consumer transaction associated with the coverage
6 if:

7 (1) the insurer represented by the license holder has
8 consented in writing, signed by an officer of the insurer, that
9 premiums are not required to be segregated from money received by
10 the license holder because of the consumer transaction associated
11 with the insurance coverage; and

12 (2) the charges for insurance coverage are itemized
13 but not billed to the consumer separately from the charges for the
14 associated consumer transaction. (V.T.I.C. Art. 21.09, Sec. 1(f).)

15 Source Law

16 (f) Notwithstanding any other provision of this
17 subchapter or any rule adopted by the commissioner, a
18 specialty license holder is not required to treat
19 premiums collected from a consumer purchasing
20 insurance when completing an associated consumer
21 transaction as money received in a fiduciary capacity
22 if:

23 (1) the insurer represented by the
24 specialty license holder has consented in writing,
25 signed by an officer of the insurer, that premiums need
26 not be segregated from money received by the license
27 holder on account of the associated consumer
28 transaction; and

29 (2) the charges for insurance coverage are
30 itemized but not billed to the consumer separately
31 from the charges for the associated consumer
32 transaction.

33 Revised Law

34 Sec. 4055.011. AUTHORITY OF EMPLOYEE OF SPECIALTY LICENSE
35 HOLDER. An employee of a specialty license holder may act as an
36 agent with respect to the kinds of insurance the license holder is
37 authorized to offer under this chapter only if the employee:

38 (1) is trained under Section 4055.012 to act
39 individually on behalf of the license holder;

40 (2) acts on behalf of and under the supervision of the
41 license holder; and

42 (3) is not compensated based primarily on the amount

1 of insurance sold by the employee under this chapter. (V.T.I.C.
2 Art. 21.09, Sec. 1(c).)

3 Source Law

4 (c) A specialty license issued under this
5 article authorizes an employee of the license holder
6 to act as an agent with respect to the kinds of
7 insurance specified in this article if the employee:

8 (1) is trained under Subsection (d) of
9 this section to act individually on behalf of the
10 specialty license holder;

11 (2) is acting on behalf of and under the
12 supervision of the license holder; and

13 (3) is not compensated based primarily on
14 the amount of insurance sold by the employee under this
15 article.

16 Revisor's Note

17 Section 1(c), V.T.I.C. Article 21.09, states that
18 an employee of a specialty license holder may act as an
19 agent with respect to the kinds of insurance
20 "specified in" Article 21.09. The revised law refers
21 instead to the kinds of insurance "the license holder
22 is authorized to offer under this chapter" because it
23 is clear, in context, that an employee may act as an
24 agent only with respect to the kinds of insurance that
25 the license holder is authorized to offer under
26 Article 21.09.

27 Revised Law

28 Sec. 4055.012. TRAINING REQUIRED TO ACT ON BEHALF OF
29 SPECIALTY LICENSE HOLDER. (a) A specialty license holder may not
30 allow an individual to act on the license holder's behalf with
31 respect to a kind of insurance that the license holder is authorized
32 to offer unless the individual has completed an approved training
33 program.

34 (b) The materials for the training program must be provided
35 to the specialty license holder by an insurer that writes the kind
36 of insurance authorized under the specialty license.

37 (c) An insurer that provides training program materials
38 under Subsection (b) must submit the training program to the
39 commissioner for approval before the training program is used.

1 (d) The training program must meet the following minimum
2 standards:

3 (1) each trainee must receive basic instruction about
4 the kinds of insurance the specialty license holder is authorized
5 to offer for purchase by prospective consumers;

6 (2) each trainee must be instructed to inform a
7 prospective consumer that, except as may be specifically provided
8 by another law of this state or the United States, the purchase of
9 the kind of insurance offered is not required to complete the
10 associated consumer transaction; and

11 (3) each trainee must be instructed with respect to
12 the disclosures required to be made to consumers. (V.T.I.C. Art.
13 21.09, Sec. 1(d).)

14 Source Law

15 (d) A person licensed under this article may not
16 allow an individual to act on the license holder's
17 behalf with respect to the specific type of insurance
18 that the license holder is authorized to offer unless
19 that individual has completed an approved training
20 program. An insurer that writes the specific type of
21 insurance for which the specialty license is sought
22 must provide the materials for the training program to
23 the license holder. The insurer must submit the
24 training program to the commissioner for approval
25 before the training program is used. The training
26 program must meet the following minimum standards:

27 (1) each trainee must receive basic
28 instruction about the kinds of insurance the license
29 holder is authorized to offer for purchase by
30 prospective consumers;

31 (2) each trainee must be instructed to
32 inform a prospective consumer that, except as may be
33 specifically provided by another law of this state or
34 the United States, the purchase of insurance specified
35 in this article is not required in order to complete
36 the associated consumer transaction; and

37 (3) each trainee must be instructed with
38 respect to the disclosures required to be made to
39 consumers.

40 Revised Law

41 Sec. 4055.013. ASSIGNMENT AND TRANSFER OF COMPENSATION BY
42 CERTAIN AGENTS. A person who is licensed as a general life,
43 accident, and health agent or as a general property and casualty
44 agent or who holds a substantially equivalent license under this
45 code, as determined by the commissioner, and who enters into a
46 contract with an insurer to act as the insurer's agent in soliciting

1 or writing policies or certificates of insurance that are subject
2 to this chapter may assign and transfer to the agent's employer any
3 commission, fee, or other compensation to be paid to the agent under
4 the agent's contract with the insurer only if the sale of the
5 insurance product occurs within the scope of the agent's
6 employment. (V.T.I.C. Art. 21.09, Sec. 1(m).)

7 Source Law

8 (m) A person who is licensed as an agent for a
9 legal reserve life insurance company or as a local
10 recording agent, or who holds a substantially
11 equivalent license under this code, as determined by
12 the commissioner, and who enters into a contract with
13 an insurer to act as the insurer's agent in soliciting
14 or writing policies or certificates of insurance
15 covered by this article may assign and transfer to the
16 agent's employer any commission, fee, or other
17 compensation to be paid to the agent under the agent's
18 contract with the insurer, but only if the sale of the
19 insurance product occurred within the scope of the
20 agent's employment.

21 Revisor's Note

22 Section 1(m), V.T.I.C. Article 21.09, refers to a
23 person who is licensed as an "agent for a legal reserve
24 life insurance company or as a local recording agent."
25 Chapter 703, Acts of the 77th Legislature, Regular
26 Session, 2001, consolidated the types of licenses
27 issued to insurance agents and eliminated the quoted
28 categories of agent licenses. V.T.I.C. Article
29 21.07-1, as added by Article 2, Chapter 703, Acts of
30 the 77th Legislature, Regular Session, 2001, merged
31 the category of "legal reserve life insurance agent"
32 into a new licensing category, that of "general life,
33 accident, and health agent." V.T.I.C. Article 21.14,
34 as amended by Article 3, Chapter 703, Acts of the 77th
35 Legislature, Regular Session, 2001, replaced the
36 category of "local recording agent" with a new
37 licensing category, that of "general property and
38 casualty agent." The revised law is drafted
39 accordingly.

1 Revised Law

2 Sec. 4055.014. DISCLOSURES REQUIRED BEFORE ISSUANCE OF
3 INSURANCE. Except as provided by Section 4055.105, insurance
4 coverage may not be issued under this chapter unless:

5 (1) at each location at which sales of the coverage
6 occur, brochures or other written materials are prominently
7 displayed and readily available to a prospective consumer that:

8 (A) summarize, clearly and correctly, the
9 material terms of the coverage offered to consumers, including the
10 identity of the insurer;

11 (B) disclose that the coverage offered by the
12 specialty license holder may duplicate coverage already provided by
13 a consumer's personal auto insurance policy, homeowner's insurance
14 policy, personal liability insurance policy, or another source of
15 coverage;

16 (C) state that, except as specifically provided
17 by another law of this state or the United States, the purchase by
18 the consumer of the kind of insurance offered is not required to
19 complete the associated consumer transaction;

20 (D) describe the process for filing a claim for
21 benefits; and

22 (E) contain any additional information required
23 by the commissioner by rule regarding the price, benefits,
24 exclusions, conditions, or other limitations of the coverage; and

25 (2) evidence of coverage is provided to each consumer
26 who purchases the coverage. (V.T.I.C. Art. 21.09, Secs. 1(g), 2(d)
27 (part), 4(d), 5(d), 7(d).)

28 Source Law

29 [Sec. 1]

30 (g) Insurance may not be issued under this
31 article unless:

32 (1) at each location at which sales of
33 insurance policies covered by this article occur,
34 brochures or other written materials are prominently
35 displayed and readily available to the prospective
36 consumer that:

37 (A) summarize, clearly and
38 correctly, the material terms of insurance coverage
39 offered to consumers, including the identity of the

1 insurer;

2 (B) disclose that the policies
3 offered by the license holder may provide a
4 duplication of coverage already provided by a
5 consumer's personal auto insurance policy, homeowner's
6 insurance policy, personal liability insurance
7 policy, or other source of coverage;

8 (C) state that, except as
9 specifically provided by another law of this state or
10 the United States, the purchase by the consumer of the
11 kinds of insurance specified in this article is not
12 required to complete the associated consumer
13 transaction;

14 (D) describe the process for filing a
15 claim in the event the consumer elects to purchase
16 coverage and in the event of a claim; and

17 (E) contain any additional
18 information on the price, benefits, exclusions,
19 conditions, or other limitations of the policies
20 required by the commissioner by rule; and

21 (2) evidence of coverage is provided to
22 each consumer who elects to purchase the coverage.

23 [Sec. 2]

24 (d) Insurance may not be issued under this
25 section unless:

26 . . .
27 (2) the brochures or other written
28 materials containing the disclosures required by
29 Section 1(g) of this article are prominently displayed
30 and readily available to the prospective renter of a
31 vehicle or vehicle equipment.

32 [Sec. 4]

33 (d) Insurance may not be issued under this
34 section unless the brochures or other written
35 materials containing the disclosures required by
36 Section 1(g) of this article are prominently displayed
37 and readily available to the prospective traveler.

38 [Sec. 5]

39 (d) Insurance may not be issued under this
40 section unless the brochures or other written
41 materials containing the disclosures required by
42 Section 1(g) of this article are prominently displayed
43 and readily available to the prospective renter.

44 [Sec. 7]

45 (d) Insurance may not be issued under this
46 section unless the brochures or other written
47 materials containing the disclosures required by
48 Section 1(g) of this article are prominently displayed
49 and readily available to the prospective purchaser of
50 the insurance coverage.

51 Revisor's Note

52 Section 1(g), V.T.I.C. Article 21.09, refers to
53 the process for filing a claim "in the event the
54 consumer elects to purchase coverage and in the event
55 of a claim." The revised law omits the quoted language
56 as unnecessary and instead refers to the process for
57 filing a claim "for benefits" because a claim may not

1 be filed unless coverage is purchased.

2 Revised Law

3 Sec. 4055.015. VIOLATION BY SPECIALTY LICENSE HOLDER;
4 PENALTIES. If a specialty license holder violates this title, the
5 commissioner may:

6 (1) impose any disciplinary action authorized by
7 Subchapter C, Chapter 4005; or

8 (2) after notice and opportunity for hearing, impose
9 other penalties, including suspending the transaction of insurance
10 at specific locations where a violation of this title has occurred,
11 as the commissioner considers necessary or appropriate to implement
12 the purposes of this title. (V.T.I.C. Art. 21.09, Sec. 1(h).)

13 Source Law

14 (h) If a specialty license holder violates this
15 subchapter, the commissioner may:

16 (1) impose any disciplinary action
17 authorized by Article 21.01-2 of this code; or

18 (2) after notice and opportunity for
19 hearing, impose other penalties, including suspending
20 the transaction of insurance at specific locations
21 where a violation of this subchapter has occurred, as
22 the commissioner considers necessary or appropriate to
23 implement the purposes of this subchapter.

24 [Sections 4055.016-4055.050 reserved for expansion]

25 SUBCHAPTER B. RENTAL CAR COMPANY LICENSE

26 Revised Law

27 Sec. 4055.051. DEFINITIONS. In this subchapter:

28 (1) "Rental agreement" means a written agreement that
29 states the terms and conditions governing the use of a vehicle or
30 vehicle equipment provided by a rental car company.

31 (2) "Rental car company" means a person engaged in the
32 business of providing leased or rented vehicles or vehicle
33 equipment to the public.

34 (3) "Renter" means a person who obtains the use of a
35 vehicle or vehicle equipment from a rental car company under the
36 terms of a rental agreement.

37 (4) "Vehicle" means:

38 (A) a private passenger motor vehicle, including

1 passenger vans and minivans that are primarily intended for the
2 transport of persons;

3 (B) a motor home;

4 (C) a motorcycle;

5 (D) a trailer with a gross vehicle weight rating
6 of 10,000 pounds or less; or

7 (E) a truck with a gross vehicle weight rating of
8 26,000 pounds or less and the operation of which does not require a
9 commercial driver's license.

10 (5) "Vehicle equipment" means a cartop carrier, tow
11 bar, or tow dolly specifically designed for use with a vehicle.
12 (V.T.I.C. Art. 21.09, Sec. 2(a).)

13 Source Law

14 Sec. 2. (a) In this section:

15 (1) "Rental agreement" means a written
16 agreement that sets forth the terms and conditions
17 governing the use of a vehicle or vehicle equipment
18 provided by a rental car company.

19 (2) "Rental car company" means a person
20 engaged in the business of providing leased or rented
21 vehicles or vehicle equipment to the public.

22 (3) "Renter" means a person who obtains
23 the use of a vehicle or vehicle equipment from a rental
24 car company under the terms of a rental agreement.

25 (4) "Vehicle" means:

26 (A) a private passenger motor
27 vehicle, including passenger vans and minivans that
28 are primarily intended for the transport of persons;

29 (B) a motor home;

30 (C) a motorcycle;

31 (D) a trailer with a gross vehicle
32 weight rating of 10,000 pounds or less; or

33 (E) a truck with a gross vehicle
34 weight rating of 26,000 pounds or less the operation of
35 which does not require a commercial driver's license.

36 (5) "Vehicle equipment" means a cartop
37 carrier, tow bar, or tow dolly specifically designed
38 for use with a vehicle.

39 Revised Law

40 Sec. 4055.052. ISSUANCE OF LICENSE. Notwithstanding any
41 other provision of this chapter or this code, the commissioner
42 shall issue a specialty license to a rental car company, or to the
43 franchisee of a rental car company, that complies with this
44 subchapter. The specialty license may be issued only for the
45 limited purposes specified by this subchapter. (V.T.I.C. Art.
46 21.09, Sec. 2(b).)

1 exceeds 30 consecutive days. (V.T.I.C. Art. 21.09, Secs. 2(c), (d)
2 (part).)

3 Source Law

4 (c) The rental car company or franchisee
5 licensed under Section 1 of this article may act as an
6 agent for an authorized insurer only in connection
7 with the rental of vehicles or vehicle equipment and
8 only with respect to:

9 (1) excess liability insurance that
10 provides coverage to the rental car company or
11 franchisee and renters and other authorized drivers of
12 rental vehicles, in excess of the standard liability
13 limits provided by the rental car company in the rental
14 agreement, for liability arising from the negligent
15 operation or use of the rental vehicle or vehicle
16 equipment;

17 (2) accident and health insurance that
18 provides coverage to renters and other vehicle
19 occupants for accidental death or dismemberment and
20 for medical expenses resulting from an accident
21 involving the rental vehicle or vehicle equipment that
22 occurs during the rental period;

23 (3) personal effects insurance that
24 provides coverage to renters and other rental vehicle
25 occupants for the loss of, or damage to, personal
26 effects or household belongings that occurs during the
27 rental period; or

28 (4) any other coverage that the
29 commissioner may approve as meaningful and appropriate
30 in connection with the rental of vehicles or vehicle
31 equipment.

32 (d) Insurance may not be issued under this
33 section unless:

34 (1) the rental period under the rental
35 agreement does not exceed 30 consecutive days;
36 and

37 [Sections 4055.054-4055.100 reserved for expansion]

38 SUBCHAPTER C. CREDIT INSURANCE LICENSE

39 Revised Law

40 Sec. 4055.101. GENERAL DEFINITIONS. In this subchapter:

41 (1) "Credit insurance" includes:

42 (A) credit life insurance;

43 (B) credit accident and health insurance;

44 (C) credit property insurance;

45 (D) credit involuntary unemployment insurance;

46 and

47 (E) insurance that covers the difference between
48 the actual cash value of a motor vehicle used as security for a loan
49 or lease and the outstanding balance of that loan or lease if loss
50 or damage renders the vehicle an actual or constructive total loss

1 while the debt for which the vehicle serves as security exceeds the
2 actual cash value of the vehicle.

3 (2) "Credit insurance agent" means a person licensed
4 under this chapter to sell credit insurance as specifically
5 provided by this subchapter. (V.T.I.C. Art. 21.09, Secs. 3(a)(1),
6 (2).)

7 Source Law

8 Sec. 3. (a) In this section:

9 (1) "Credit insurance" includes:

10 (A) credit life insurance;
11 (B) credit accident and health
12 insurance;

13 (C) credit property insurance;

14 (D) credit involuntary unemployment
15 insurance; and

16 (E) insurance that covers the
17 difference between the actual cash value of a motor
18 vehicle used as security for a loan or lease and the
19 outstanding balance of that loan or lease in the event
20 of loss or damage in which the vehicle is rendered an
21 actual or constructive total loss while the debt for
22 which the vehicle serves as security exceeds the
23 actual cash value of the vehicle.

24 (2) "Credit insurance agent" means a
25 person licensed to sell credit insurance under this
26 article as specifically provided by this section.

27 Revised Law

28 Sec. 4055.102. DEFINITION OF CREDIT PROPERTY
29 INSURANCE. (a) In this subchapter, "credit property insurance"
30 means insurance that covers personal property:

31 (1) used as security for a personal or consumer loan;
32 or

33 (2) under an installment sales agreement or through a
34 consumer credit transaction that is purchased in connection with or
35 in relation to the personal or consumer loan, installment sale, or
36 consumer credit transaction.

37 (b) "Credit property insurance" does not include insurance
38 that:

39 (1) provides theft, collision, liability, property
40 damage, or comprehensive insurance coverage on an automobile,
41 motorized aircraft, motorcycle, truck, truck-tractor, traction
42 engine, or any other self-propelled vehicle or craft that is
43 designed primarily for operation in the air, or on highways,

1 roadways, waterways, or the sea, and the operating equipment of the
2 self-propelled vehicle or craft; or

3 (2) is necessary because of liability imposed by law
4 for damages arising out of the ownership, operation, maintenance,
5 or use of a vehicle or craft described by Subdivision (1), other
6 than single interest coverage on any vehicle or craft described by
7 Subdivision (1) that insures the interest of the creditor in the
8 same manner as security for a loan. (V.T.I.C. Art. 21.09, Sec.
9 3(a)(3).)

10 Source Law

11 (3) "Credit property insurance" means
12 insurance that provides coverage on personal property
13 used as collateral for securing a personal or consumer
14 loan or on personal property under an installment
15 sales agreement or through a consumer credit
16 transaction that is purchased in connection with or in
17 relation to the personal or consumer loan, installment
18 sale, or consumer credit transaction. The term does
19 not include insurance that provides theft, collision,
20 liability, property damage, or comprehensive
21 insurance coverage on an automobile, motorized
22 aircraft, motorcycle, truck, truck-tractor, traction
23 engine, or any other self-propelled vehicle that is
24 designed primarily for operation in the air, or on
25 highways, roadways, waterways, or the sea, and the
26 operating equipment of the self-propelled vehicle or
27 craft, or that is necessitated by reason of the
28 liability imposed by law for damages arising out of the
29 ownership, operation, maintenance, or use of any of
30 those vehicles and crafts, other than single interest
31 coverage on any vehicle or craft described in this
32 subdivision that insures the interest of the creditor
33 in the same manner as collateral for a loan.

34 Revised Law

35 Sec. 4055.103. ISSUANCE OF LICENSE. Notwithstanding any
36 other provision of this chapter or this code, the commissioner may
37 issue a specialty license to a retail distributor of goods, an
38 automobile dealer, a bank, a state or federal savings and loan, a
39 state or federal credit union, a finance company, a production
40 credit association, a manufactured home retailer, or a mobile home
41 retailer that complies with this subchapter. The specialty license
42 may be issued only for the limited purposes specified by this
43 subchapter. (V.T.I.C. Art. 21.09, Sec. 3(b).)

44 Source Law

45 (b) Notwithstanding any other provision of this

1 article or this code, the commissioner may issue a
2 license under Section 1 of this article to a retail
3 distributor of goods, an automobile dealer, a bank, a
4 state or federal savings and loan, a state or federal
5 credit union, a finance company, a production credit
6 association, a manufactured home retailer, or a mobile
7 home retailer that complies with this section only for
8 the limited purposes set forth in this section.

9 Revised Law

10 Sec. 4055.104. AUTHORITY OF CREDIT INSURANCE AGENT. A
11 credit insurance agent appointed by an insurer authorized to engage
12 in the business of insurance under this code may act as the agent
13 for the insurer in the sale of any kind of credit insurance in the
14 business of which the insurer is authorized to engage, including
15 individual or group credit insurance. (V.T.I.C. Art. 21.09, Sec.
16 3(c).)

17 Source Law

18 (c) On appointment by the insurance company, a
19 credit insurance agent may act as the agent of any
20 company authorized to engage in the business of
21 insurance under this code in the sale of any type of
22 credit insurance that the company is authorized to
23 write. The authority conferred under this section
24 specifically permits the sale of both individual and
25 group credit insurance.

26 Revised Law

27 Sec. 4055.105. EXEMPTION FROM CERTAIN DISCLOSURE
28 REQUIREMENTS. A specialty license holder and the license holder's
29 representative are not required to make the disclosures required by
30 Section 4055.014 as that section relates to the sale or delivery of
31 a credit insurance product that is subject to this subchapter if the
32 license holder or representative complies with all disclosure
33 requirements prescribed by another provision of this code or
34 another law of this state or the United States with regard to the
35 sale or delivery of that product. (V.T.I.C. Art. 21.09, Sec. 3(d).)

36 Source Law

37 (d) A license holder and the license holder's
38 representative are not required to make the
39 disclosures required by Section 1(g) of this article
40 if the license holder or the license holder's
41 representative complies with all disclosure
42 requirements prescribed by another provision of this
43 code or another law of this state or the United States
44 relating to the sale or delivery of a credit insurance
45 product that is subject to this section.

1 [Sections 4055.106-4055.150 reserved for expansion]

2 SUBCHAPTER D. TRAVEL INSURANCE LICENSE

3 Revised Law

4 Sec. 4055.151. DEFINITIONS. In this subchapter:

5 (1) "Planned trip" means any journey or travel
6 arranged through the services of a travel agency.

7 (2) "Travel agency" means an entity engaged in the
8 business of selling or arranging transportation or accommodations
9 for the public.

10 (3) "Traveler" means an individual who seeks the
11 assistance of a travel agency in connection with the planning and
12 purchase of a trip. (V.T.I.C. Art. 21.09, Sec. 4(a).)

13 Source Law

14 Sec. 4. (a) In this section:

15 (1) "Planned trip" means any journey or
16 travel arranged through the services of a travel
17 agency.

18 (2) "Travel agency" means an entity
19 engaged in the business of selling or arranging
20 transportation or accommodations for the public.

21 (3) "Traveler" means an individual who
22 seeks the assistance of a travel agency in connection
23 with the planning and purchase of a trip.

24 Revised Law

25 Sec. 4055.152. ISSUANCE OF LICENSE. Notwithstanding any
26 other provision of this chapter or this code, the commissioner may
27 issue a specialty license to a travel agency, the franchisee of a
28 travel agency, or a public carrier that complies with this
29 subchapter. The specialty license may be issued only for the
30 limited purposes specified by this subchapter. (V.T.I.C. Art.
31 21.09, Sec. 4(b).)

32 Source Law

33 (b) Notwithstanding any other provision of this
34 article or this code, the commissioner may issue a
35 specialty license under Section 1 of this article to a
36 travel agency, the franchisee of a travel agency, or a
37 public carrier that complies with this section only
38 for the limited purposes set forth in this section.

39 Revised Law

40 Sec. 4055.153. AUTHORITY OF TRAVEL AGENCY OR FRANCHISEE. A
41 travel agency or franchisee licensed under this chapter may act as

1 an agent for an authorized insurer only:

2 (1) in connection with the sale or arrangement of
3 transportation or accommodations for travelers; and

4 (2) with respect to:

5 (A) accident and health insurance that provides
6 coverage to a traveler for accidental death or dismemberment and
7 for medical expenses resulting from an accident involving the
8 traveler that occurs during the planned trip;

9 (B) insurance that provides coverage to a
10 traveler for expenses incurred as a result of trip cancellation or
11 interruption of a planned trip;

12 (C) personal effects insurance that provides
13 coverage to a traveler for loss of or damage to personal effects
14 during the planned trip;

15 (D) life insurance not exceeding \$150,000 on any
16 one life covering risks of travel during a planned trip; or

17 (E) any other coverage the commissioner approves
18 as meaningful and appropriate in connection with the transportation
19 or accommodations arranged through a travel agency. (V.T.I.C. Art.
20 21.09, Sec. 4(c).)

21 Source Law

22 (c) The travel agency or franchisee licensed
23 under Section 1 of this article may act as an agent for
24 any authorized insurer only in connection with the
25 sale or arrangement of transportation or
26 accommodations for travelers and only with respect to:

27 (1) accident and health insurance that
28 provides coverage to a traveler for accidental death
29 or dismemberment and for medical expenses resulting
30 from an accident involving the traveler that occurs
31 during the planned trip;

32 (2) insurance that provides coverage to a
33 traveler for expenses incurred as a result of trip
34 cancellation or interruption of a planned trip;

35 (3) personal effects insurance that
36 provides coverage to a traveler for the loss of, or
37 damage to, personal effects that occurs during the
38 planned trip;

39 (4) life insurance covering risks of
40 travel during a planned trip that does not exceed
41 \$150,000 on any one life; or

42 (5) any other coverage that the
43 commissioner may approve as meaningful and appropriate
44 in connection with the transportation or
45 accommodations arranged through a travel agency.

1 [Sections 4055.154-4055.200 reserved for expansion]

2 SUBCHAPTER E. SELF-SERVICE STORAGE FACILITY LICENSE

3 Revised Law

4 Sec. 4055.201. DEFINITIONS. In this subchapter:

5 (1) "Rental agreement" means a written agreement that
6 states the terms governing the use of storage space provided by a
7 self-service storage facility.

8 (2) "Renter" means a person who obtains the use of
9 storage space from a self-service storage facility under a rental
10 agreement.

11 (3) "Self-service storage facility" means a person
12 engaged in the business of providing leased or rented storage space
13 to the public.

14 (4) "Storage space" means a room, unit, locker, or
15 open space offered for rental to the public for temporary storage of
16 personal belongings or light commercial goods. (V.T.I.C. Art.
17 21.09, Sec. 5(a).)

18 Source Law

19 Sec. 5. (a) In this section:

20 (1) "Rental agreement" means a written
21 agreement that sets forth the terms and conditions
22 governing the use of storage space provided by a
23 self-service storage facility.

24 (2) "Renter" means a person who obtains
25 the use of storage space from a self-service storage
26 facility under a rental agreement.

27 (3) "Self-service storage facility" means
28 a person engaged in the business of providing leased or
29 rented storage space to the public.

30 (4) "Storage space" means a room, unit,
31 locker, or open space offered for rental to the public
32 for temporary storage of personal belongings or light
33 commercial goods.

34 Revised Law

35 Sec. 4055.202. ISSUANCE OF LICENSE. Notwithstanding any
36 other provision of this chapter or this code, the commissioner may
37 issue a specialty license to a self-service storage facility or to
38 the franchisee of a self-service storage facility that complies
39 with this subchapter. The specialty license may be issued only for
40 the limited purposes specified by this subchapter. (V.T.I.C. Art.
41 21.09, Sec. 5(b).)

1 pagers, automatic answering devices, batteries, and other devices
2 used to originate or receive wireless communications exclusive of
3 cordless, wireline communications. (V.T.I.C. Art. 21.09, Sec.
4 7(a).)

5 Source Law

6 Sec. 7. (a) In this section:

7 (1) "Customer" means a person who
8 purchases telecommunications equipment in a retail
9 sales transaction.

10 (2) "Telecommunications equipment"
11 includes handsets, pagers, automatic answering
12 devices, batteries, and other devices used to
13 originate or receive wireless communications
14 exclusive of cordless, wireline communications.

15 Revised Law

16 Sec. 4055.252. ISSUANCE OF LICENSE. Notwithstanding any
17 other provision of this chapter or this code, the commissioner may
18 issue a specialty license to a retail vendor of telecommunications
19 equipment who complies with this subchapter. The specialty license
20 may be issued only for the limited purposes specified by this
21 subchapter. (V.T.I.C. Art. 21.09, Sec. 7(b).)

22 Source Law

23 (b) Notwithstanding any other provision of this
24 article or this code, the commissioner may issue a
25 specialty license under Section 1 of this article to a
26 retail vendor of telecommunications equipment who
27 complies with this section only for the limited
28 purposes set forth in this section.

29 Revised Law

30 Sec. 4055.253. AUTHORITY OF RETAIL VENDOR OF
31 TELECOMMUNICATIONS EQUIPMENT. A retail vendor of
32 telecommunications equipment licensed under this chapter may act as
33 an agent for an authorized insurer only:

34 (1) in connection with the sale and use of
35 telecommunications equipment; and

36 (2) with respect to:

37 (A) insurance coverage provided to customers for
38 the loss or malfunction of or damage to telecommunications
39 equipment; or

40 (B) any other coverage the commissioner approves

1 as meaningful and appropriate in connection with the use of
2 telecommunications equipment. (V.T.I.C. Art. 21.09, Sec. 7(c).)

3 Source Law

4 (c) A retail vendor of telecommunications
5 equipment licensed under Section 1 of this article may
6 act as an agent for any authorized insurer only in
7 connection with the sale and use of telecommunications
8 equipment and only with respect to:

9 (1) insurance that provides coverage to
10 customers for the loss of, the malfunction of, or
11 damage to, telecommunications equipment; or

12 (2) any other coverage the commissioner
13 may approve as meaningful and appropriate in
14 connection with the use of telecommunications
15 equipment.

16 CHAPTER 4056. NONRESIDENT AGENTS

17 SUBCHAPTER A. GENERAL PROVISIONS

18 Sec. 4056.001. APPLICABILITY OF TITLE 1886
19 Sec. 4056.002. RIGHTS OF LICENSE HOLDERS. 1886
20 Sec. 4056.003. RECIPROCAL LICENSING AGREEMENTS 1886
21 Sec. 4056.004. HOME OFFICE EMPLOYEES 1886
22 Sec. 4056.005. RULES 1887

23 [Sections 4056.006-4056.050 reserved for expansion]

24 SUBCHAPTER B. NONRESIDENT AGENT LICENSE

25 Sec. 4056.051. APPLICATION FOR NONRESIDENT AGENT LICENSE;
26 CRIMINAL HISTORY 1887
27 Sec. 4056.052. ISSUANCE OF LICENSE TO NONRESIDENT AGENT
28 LICENSED IN OTHER STATE 1888
29 Sec. 4056.053. ISSUANCE OF LICENSE TO NONRESIDENT AGENT NOT
30 LICENSED IN OTHER STATE 1889
31 Sec. 4056.054. ISSUANCE OF LICENSE TO CORPORATION OR
32 PARTNERSHIP 1890
33 Sec. 4056.055. WAIVER OF REQUIREMENTS FOR NONRESIDENT AGENT
34 LICENSED IN OTHER STATE OR JURISDICTION . . 1890
35 Sec. 4056.056. RESTRICTIONS ON LINE OF INSURANCE BUSINESS
36 FOR RECIPROCAL NONRESIDENT AGENT LICENSE . . 1891
37 Sec. 4056.057. CONTINUING EDUCATION 1892
38 Sec. 4056.058. SERVICE OF PROCESS. 1892

1 CHAPTER 4056. NONRESIDENT AGENTS

2 SUBCHAPTER A. GENERAL PROVISIONS

3 Revised Law

4 Sec. 4056.001. APPLICABILITY OF TITLE. This title applies
5 to licensing of a nonresident agent under this chapter. (V.T.I.C.
6 Art. 21.11, Sec. 3(c).)

7 Source Law

8 (c) This subchapter applies to licensing of a
9 nonresident agent under this article.

10 Revised Law

11 Sec. 4056.002. RIGHTS OF LICENSE HOLDERS. Except as
12 otherwise specifically provided by this code, an individual who is
13 not a resident of this state and to whom a license is issued under
14 this chapter has the same rights and privileges as a resident
15 license holder. (V.T.I.C. Art. 21.11, Sec. 2(a).)

16 Source Law

17 Sec. 2. (a) Except as otherwise specifically
18 provided by this code, a license issued under this
19 article to an individual who is not a resident of this
20 state grants the same rights and privileges afforded
21 to a resident license holder.

22 Revised Law

23 Sec. 4056.003. RECIPROCAL LICENSING AGREEMENTS. The
24 commissioner may enter into an agreement with the appropriate
25 official of another state as necessary to implement reciprocal
26 licensing of nonresident agents. (V.T.I.C. Art. 21.11, Sec. 1(b).)

27 Source Law

28 (b) The commissioner may enter into an agreement
29 with the appropriate official of another state as
30 necessary to implement the reciprocal licensing of
31 nonresident agents.

32 Revised Law

33 Sec. 4056.004. HOME OFFICE EMPLOYEES. This chapter does
34 not affect the authority established under Subchapter G, Chapter
35 4051, of a full-time home office salaried employee of an insurer
36 authorized to engage in the business of insurance in this state.
37 (V.T.I.C. Art. 21.11, Sec. 4.)

1 (2) the nonrefundable license application fee.

2 (b) An applicant who does not hold an insurance agent's
3 license in the applicant's state of residence must, through the law
4 enforcement agency of the state of residence, submit to the
5 department a copy of the applicant's criminal history records. The
6 department shall use the criminal history records to determine the
7 applicant's eligibility for issuance of a license in accordance
8 with this title and other laws of this state. (V.T.I.C. Art. 21.11,
9 Secs. 1(a) (part), (e).)

10 Source Law

11 Art. 21.11

12 Sec. 1. (a) [The department shall license] a
13 person who is not a resident of this state to act as a
14 nonresident agent if:

15 (1) the applicant for the nonresident
16 license has submitted to the department:

17 (A) an application on a form as
18 prescribed by the department; and

19 (B) the nonrefundable license
20 application fee; and

21 . . .

22 (e) An applicant for a nonresident agent's
23 license from this state who does not hold an insurance
24 agent's license in the applicant's state of residence
25 shall, through the law enforcement agency of the state
26 of residence, submit a copy of the applicant's criminal
27 history records to the department. The department
28 shall use the criminal history records to determine
29 eligibility for issuance of a license in accordance
30 with this subchapter and other laws of this state.

31 Revised Law

32 Sec. 4056.052. ISSUANCE OF LICENSE TO NONRESIDENT AGENT
33 LICENSED IN OTHER STATE. (a) The department shall issue a license
34 to an applicant under this chapter if:

35 (1) the applicant holds a license in good standing as
36 an agent in the applicant's state of residence; and

37 (2) the applicant's state of residence will grant a
38 nonresident agent license on a reciprocal basis to a resident agent
39 of this state.

40 (b) The department may issue a reciprocal nonresident agent
41 license to an applicant if the authority granted by the license
42 issued by the applicant's state of residence is generally
43 comparable to the authority granted by a license issued by this

1 state. (V.T.I.C. Art. 21.11, Secs. 1(a) (part), 3(a).)

2 Source Law

3 Sec. 1. (a) The department shall license a
4 person who is not a resident of this state to act as a
5 nonresident agent if:

6 . . .
7 (2) the department finds that the
8 applicant for the nonresident license:

9 (A) holds a license in good standing
10 as an agent in the applicant's state of residence and
11 that state will grant a nonresident agent's license on
12 a reciprocal basis to a resident agent of this state;
13 or

14 . . .

15 Sec. 3. (a) The department may issue a
16 reciprocal nonresident license to an applicant if the
17 authority granted by the license issued by the
18 applicant's state of residence is generally comparable
19 to the authority granted by a license issued by this
20 state.

21 Revised Law

22 Sec. 4056.053. ISSUANCE OF LICENSE TO NONRESIDENT AGENT NOT
23 LICENSED IN OTHER STATE. The department shall issue a license to
24 an applicant under this chapter if the applicant has:

25 (1) passed the examination for an agent's license
26 required under this title;

27 (2) met the eligibility requirements for issuance of a
28 license after an examination of the applicant's criminal history
29 records under Section 4056.051(b); and

30 (3) satisfied the requirements for a license for an
31 individual under this code, including Subchapter C, Chapter 4001.

32 (V.T.I.C. Art. 21.11, Sec. 1(a) (part).)

33 Source Law

34 Sec. 1. (a) The department shall license a
35 person who is not a resident of this state to act as a
36 nonresident agent if:

37 . . .
38 (2) the department finds that the
39 applicant for the nonresident license:

40 . . .
41 (B) has:

42 (i) passed the examination for
43 an agent's license required under this code;

44 (ii) met the eligibility
45 requirements under Subsection (e) of this section; and

46 (iii) satisfied the
47 requirements for a license for an individual under
48 this code, including Section 2, Article 21.07; or

49 . . .

1 Revisor's Note

2 (1) Section 1(a)(2)(B)(i), V.T.I.C. Article
3 21.11, refers to certain examinations required under
4 "this code." The provisions of the Insurance Code
5 relating to examination of agents have been revised as
6 part of this title. The revised law is drafted
7 accordingly.

8 (2) Section 1(a)(2)(B)(ii), V.T.I.C. Article
9 21.11, refers to the eligibility requirements of
10 Subsection (e) of Section 1, revised in this chapter as
11 Section 4056.051(b). That provision requires certain
12 applicants to submit a copy of the applicant's criminal
13 history records to the department but does not
14 establish explicit eligibility requirements in
15 relation to the records required to be submitted. The
16 revised law clarifies that a license is issued after a
17 determination that the applicant has met the
18 eligibility requirements after an examination of the
19 records.

20 Revised Law

21 Sec. 4056.054. ISSUANCE OF LICENSE TO CORPORATION OR
22 PARTNERSHIP. The department shall issue a license to an applicant
23 under this chapter if the applicant has satisfied the requirements
24 for a license for a corporation or partnership under Subchapter C,
25 Chapter 4001. (V.T.I.C. Art. 21.11, Sec. 1(a) (part).)

26 Source Law

27 Sec. 1. (a) The department shall license a
28 person who is not a resident of this state to act as a
29 nonresident agent if:

30 . . .
31 (2) the department finds that the
32 applicant for the nonresident license:

33 . . .
34 (C) has satisfied the requirements
35 for a license for a corporation or partnership under
36 Section 2, Article 21.07, of this code.

37 Revised Law

38 Sec. 4056.055. WAIVER OF REQUIREMENTS FOR NONRESIDENT AGENT

1 LICENSED IN OTHER STATE OR JURISDICTION. The department may waive
2 any license requirement for an applicant who holds a valid license
3 from another state or jurisdiction if:

4 (1) that state or jurisdiction has license
5 requirements substantially equivalent to those of this state; or

6 (2) the waiver is necessary to promote reciprocal
7 licensing of nonresident agents among a majority of the states.

8 (V.T.I.C. Art. 21.11, Sec. 1(c).)

9 Source Law

10 (c) The department may waive any license
11 requirements for an applicant with a valid license
12 from another state or jurisdiction if:

13 (1) that state or jurisdiction has license
14 requirements substantially equivalent to those of this
15 state; or

16 (2) the waiver is necessary to promote
17 reciprocal licensing of nonresident agents among a
18 majority of the states.

19 Revised Law

20 Sec. 4056.056. RESTRICTIONS ON LINE OF INSURANCE BUSINESS
21 FOR RECIPROCAL NONRESIDENT AGENT LICENSE. A nonresident agent
22 licensed under Section 4056.052 may not act as a nonresident agent
23 for a line of insurance business in this state unless the agent is
24 authorized in the agent's state of residence to act in that state as
25 an agent for that line of insurance business. (V.T.I.C. Art. 21.11,
26 Sec. 3(b).)

27 Source Law

28 (b) A nonresident agent licensed under the
29 reciprocal licensing provisions of this code may not
30 engage in a line of insurance business in this state
31 for which the agent is not authorized in the agent's
32 state of residence.

33 Revisor's Note

34 (1) Section 3(b), V.T.I.C. Article 21.11,
35 refers to a nonresident agent licensed under "the
36 reciprocal licensing provisions of this code." Those
37 provisions are contained in part of Section 1(a) and
38 Section 3(a) of Article 21.11 and revised as Section
39 4056.052 of this chapter. The revised law is drafted
40 accordingly.

1 (3) the license of the nonresident agent is revoked.
2 (V.T.I.C. Art. 21.11, Sec. 1(d).)

3 Source Law

4 (d) The commissioner is the agent for service of
5 process in the manner provided by Section 3, Article
6 1.36, of this code in a legal proceeding against a
7 nonresident agent licensed to transact business in
8 this state if:

9 (1) the nonresident agent fails to appoint
10 or maintain an agent for service in this state;

11 (2) an agent for service is appointed but
12 cannot with reasonable diligence be found; or

13 (3) the license of the nonresident agent
14 is revoked.

15 Revisor's Note
16 (End of Chapter)

17 (1) V.T.I.C. Article 21.10 requires that
18 certain insurers file an affidavit before a
19 certificate or license is issued. The affidavit must
20 state that the insurer has not violated any provision
21 of Articles 21.09, 21.11, 21.12, and 21.13. The
22 revised law omits Article 21.10, which has not been
23 amended since it was enacted as part of the Insurance
24 Code of 1951, because it is no longer possible for an
25 insurer to violate the listed articles. Former
26 Article 21.09, as it existed at the time of enactment
27 of the Insurance Code in 1951, regulated the
28 activities of nonresident agents in this state and was
29 repealed by Chapter 596, Acts of the 75th Legislature,
30 Regular Session, 1997. Article 21.11, revised as this
31 chapter, formerly regulated the payment of commissions
32 to nonresident agents. Article 21.11 has been
33 substantially rewritten since 1951; the article now
34 provides for licensing of nonresident agents and no
35 longer establishes a prohibition that may be violated.
36 Article 21.12 is omitted from the revised law for the
37 reason stated in Revisor's Note (2) following this
38 note; this article also does not establish a
39 prohibition that may be violated. Former Article

1 21.13, which established penalties for certain
2 violations, was repealed by Section 12.51, Chapter
3 685, Acts of the 73rd Legislature, Regular Session,
4 1993. The omitted law reads:

5 Art. 21.10. Before a certificate or
6 license to any fire, fire and marine,
7 marine, tornado, rent, accident, casualty,
8 liability, health, elevator, disability,
9 plate glass, burglary, bonding, title,
10 surety or fidelity insurance company is
11 issued authorizing it to transact business
12 in this State, the Board shall require in
13 every case, in addition to the other
14 requirements already made and provided by
15 the law, that each such insurance company
16 shall file with the Board an affidavit that
17 it has not violated any provision of
18 Articles 21.09, 21.11, 21.12, and 21.13 of
19 this code.

20 (2) V.T.I.C. Article 21.12 authorizes the
21 "Board," meaning the Texas Department of Insurance, to
22 examine the books, records, and papers of certain
23 insurers in relation to investigations of certain
24 violations of law, permits examination of certain
25 persons, and authorizes related procedures. An
26 insurer that does not comply with the requirements of
27 the department as required by Article 21.12 is subject
28 to the penalties of V.T.I.C. Article 21.13. The
29 revised law omits Article 21.12 as redundant of
30 V.T.I.C. Article 1.19, which imposes substantively
31 identical requirements on all insurers and which
32 applies in all circumstances, including the
33 investigations described by Article 21.12. In
34 addition, former Article 21.13, which established the
35 applicable penalties, was repealed by Section 12.51,
36 Chapter 685, Acts of the 73rd Legislature, Regular
37 Session, 1993. The omitted law reads:

38 Art. 21.12. The Board is hereby
39 authorized, and it is made its duty, at the
40 expense of the company investigating, to
41 examine at the head office, located within
42 the United States of America, all books,
43 records and papers of such company and also
44 any officers or employees thereof under

1 oath, as to violations of this article or
 2 Articles 21.09, 21.10, 21.11, or 21.13 of
 3 this code and the Board is further empowered
 4 to examine person or persons, administer
 5 oaths, and send for papers and records, and
 6 failure or refusal upon the part of any
 7 life, fire and marine, marine, tornado,
 8 rent, accident, casualty, liability,
 9 health, elevator, disability, plate glass,
 10 burglary, bonding, title, surety or
 11 fidelity insurance company, person or
 12 persons, agent, firm or corporation,
 13 licensed to do business in the State of
 14 Texas to appear before the Board when
 15 requested to do so, or to produce records
 16 and papers, or answer under oath, shall
 17 subject such fire, fire and marine, marine,
 18 tornado, rent, accident, casualty,
 19 liability, health, elevator, disability,
 20 plate glass, burglary, bonding, title,
 21 surety or fidelity insurance company,
 22 person, persons, agent, firm or corporation
 23 to the penalties of Article 21.13 of this
 24 code.

25 [Chapters 4057-4100 reserved for expansion]

26 SUBTITLE C. ADJUSTERS

27 CHAPTER 4101. INSURANCE ADJUSTERS

28 SUBCHAPTER A. GENERAL PROVISIONS

29 Sec. 4101.001. DEFINITIONS 1896
 30 Sec. 4101.002. GENERAL EXEMPTIONS 1898
 31 Sec. 4101.003. TEMPORARY EXEMPTION 1900
 32 Sec. 4101.004. RECIPROCITY 1901
 33 Sec. 4101.005. RULES 1901
 34 Sec. 4101.006. ADVISORY BOARD 1902

35 [Sections 4101.007-4101.050 reserved for expansion]

36 SUBCHAPTER B. LICENSE REQUIREMENTS

37 Sec. 4101.051. LICENSE REQUIRED. 1905
 38 Sec. 4101.052. APPLICATION 1905
 39 Sec. 4101.053. QUALIFICATIONS; ISSUANCE 1906
 40 Sec. 4101.054. EXAMINATION REQUIRED 1907
 41 Sec. 4101.055. EXAMINATION PROCEDURES 1908
 42 Sec. 4101.056. EXEMPTION FROM EXAMINATION REQUIREMENT 1909
 43 Sec. 4101.057. FEES. 1911
 44 Sec. 4101.058. LICENSE FORM 1912
 45 Sec. 4101.059. CONTINUING EDUCATION: GENERAL
 46 REQUIREMENTS 1913

1 Sec. 4101.060. CONTINUING EDUCATION: EXEMPTIONS AND
2 WAIVERS 1914
3 Sec. 4101.061. EXPIRATION; RENEWAL 1914
4 [Sections 4101.062-4101.100 reserved for expansion]
5 SUBCHAPTER C. SPECIAL LICENSES
6 Sec. 4101.101. EMERGENCY LICENSE 1915
7 Sec. 4101.102. LIMITED LICENSE 1916
8 [Sections 4101.103-4101.150 reserved for expansion]
9 SUBCHAPTER D. POWERS AND DUTIES OF ADJUSTER
10 Sec. 4101.151. PLACE OF BUSINESS 1917
11 Sec. 4101.152. REFERRAL BY INSURER 1917
12 [Sections 4101.153-4101.200 reserved for expansion]
13 SUBCHAPTER E. ENFORCEMENT
14 Sec. 4101.201. GROUNDS FOR DISCIPLINARY ACTION 1918
15 Sec. 4101.202. REINSTATEMENT OR REISSUANCE OF LICENSE 1918
16 Sec. 4101.203. CRIMINAL PENALTY. 1919

17 CHAPTER 4101. INSURANCE ADJUSTERS
18 SUBCHAPTER A. GENERAL PROVISIONS

19 Revised Law

20 Sec. 4101.001. DEFINITIONS. (a) In this chapter,
21 "adjuster" means an individual who:
22 (1) investigates or adjusts losses on behalf of an
23 insurer as an independent contractor or as an employee of:
24 (A) an adjustment bureau;
25 (B) an association;
26 (C) a general property and casualty agent;
27 (D) an independent contractor;
28 (E) an insurer; or
29 (F) a managing general agent; or
30 (2) supervises the handling of claims.
31 (b) For purposes of this chapter, "insurer" includes a
32 self-insured. (V.T.I.C. Art. 21.07-4, Secs. 1(a), (c).)

33 Source Law

34 Art. 21.07-4

1 Revised Law

2 Sec. 4101.002. GENERAL EXEMPTIONS. (a) This chapter does
3 not apply to:

4 (1) an attorney who:

5 (A) adjusts insurance losses periodically and
6 incidentally to the practice of law; and

7 (B) does not represent that the attorney is an
8 adjuster;

9 (2) a salaried employee of an insurer who is not
10 regularly engaged in the adjustment, investigation, or supervision
11 of insurance claims;

12 (3) a person employed only to furnish technical
13 assistance to a licensed adjuster, including:

14 (A) an attorney;

15 (B) an engineer;

16 (C) an estimator;

17 (D) a handwriting expert;

18 (E) a photographer; and

19 (F) a private detective;

20 (4) an agent or general agent of an authorized insurer
21 who processes an undisputed or uncontested loss for the insurer
22 under a policy issued by the agent or general agent;

23 (5) a person who performs clerical duties and does not
24 negotiate with parties to disputed or contested claims;

25 (6) a person who handles claims arising under life,
26 accident, and health insurance policies;

27 (7) a person:

28 (A) who is employed principally as:

29 (i) a right-of-way agent; or

30 (ii) a right-of-way and claims agent;

31 (B) whose primary responsibility is the
32 acquisition of easements, leases, permits, or other real property
33 rights; and

34 (C) who handles only claims arising out of

1 operations under those easements, leases, permits, or other
2 contracts or contractual obligations; or

3 (8) an individual who is employed to investigate
4 suspected fraudulent insurance claims but who does not adjust
5 losses or determine claims payments.

6 (b) A nonresident adjuster is not required to hold a license
7 under this chapter to:

8 (1) adjust a single loss in this state;

9 (2) adjust losses arising out of a catastrophe common
10 to all those losses; or

11 (3) act as a temporary substitute for a licensed
12 adjuster. (V.T.I.C. Art. 21.07-4, Secs. 1(b), 2(a) (part).)

13 Source Law

14 [Sec. 1]

15 (b) "Adjuster" shall not include:

16 (1) an attorney at law who adjusts
17 insurance losses from time to time and incidental to
18 the practice of law, and who does not advertise or
19 represent that he is an adjuster;

20 (2) a salaried employee of an insurer who
21 is not regularly engaged in the adjustment,
22 investigation, or supervision of insurance claims;

23 (3) persons employed only for the purpose
24 of furnishing technical assistance to a licensed
25 adjuster, including, but not limited to,
26 photographers, estimators, private detectives,
27 engineers, handwriting experts, and attorneys at law;

28 (4) a licensed agent or general agent of an
29 authorized insurer who processes undisputed and/or
30 uncontested losses for such insurer under policies
31 issued by said agent or general agent;

32 (5) a person who performs clerical duties
33 with no negotiations with the parties on disputed
34 and/or contested claims;

35 (6) any person who handles claims arising
36 under life, accident and health insurance policies;

37 (7) a person who is employed principally
38 as a right-of-way agent or right-of-way and claims
39 agent and whose primary responsibility is the
40 acquisition of easements, leases, permits, or other
41 real property rights and whose claims handling arises
42 out of operations under those easements, leases,
43 permits, or other contracts or contractual
44 obligations; or

45 (8) an individual who is employed to
46 investigate suspected fraudulent insurance claims but
47 who does not adjust losses or determine claims
48 payments.

49 Sec. 2. (a) . . . No license shall be
50 required under this article of a nonresident insurance
51 adjuster for the adjustment in this state of a single
52 loss, or losses arising out of a catastrophe common to
53 all such losses, or who is acting as a temporary

1 substitute for a licensed adjuster unless as outlined
2 specifically in a separate section of this law.

3 Revisor's Note

4 (1) Section 1(b)(1), V.T.I.C. Article 21.07-4,
5 refers to an attorney who "does not advertise or
6 represent that he is an adjuster." The revised law
7 omits the reference to "advertise" because, in the
8 context in which the term appears, "advertise" is
9 included in the meaning of "represent."

10 (2) Section 1(b)(3), V.T.I.C. Article 21.07-4,
11 refers to "including but not limited to." The revised
12 law omits "but not limited to" because Section
13 311.005(13), Government Code (Code Construction Act),
14 provides that "including" is a term of enlargement and
15 not of limitation and does not create a presumption
16 that components not expressed are excluded.

17 (3) Section 1(b)(4), V.T.I.C. Article 21.07-4,
18 refers to a "licensed agent or general agent of an
19 authorized insurer." The revised law omits the
20 reference to "licensed" as unnecessary in this context
21 because under Section 1, V.T.I.C. Article 21.07,
22 revised in relevant part as Section 4001.101 of this
23 code, a person may not act as an agent without holding
24 a license.

25 (4) Section 2(a), V.T.I.C. Article 21.07-4,
26 exempts, under certain circumstances, a nonresident
27 adjuster from the licensing requirements of this
28 chapter, "unless as outlined specifically in a
29 separate section of this law." The revised law omits
30 the quoted language as unnecessary because any section
31 that would require a nonresident adjuster to be
32 licensed under the circumstances described is
33 effective on its own terms.

34 Revised Law

35 Sec. 4101.003. TEMPORARY EXEMPTION. An individual who is

1 undergoing training as an adjuster under the supervision of a
2 licensed adjuster may act as an adjuster for a period not to exceed
3 12 months without having a license issued under this chapter if, at
4 the beginning of the period, the individual has been registered
5 with the commissioner as a trainee. (V.T.I.C. Art. 21.07-4, Sec.
6 2(a) (part).)

7 Source Law

8 Sec. 2. (a) . . . except that an individual,
9 who is undergoing education and training as an
10 adjuster under the direction and supervision of a
11 licensed adjuster, may for a period not exceeding 12
12 months act as an adjuster without having an adjuster's
13 license, if at the beginning of such training period,
14 the name of such trainee has been registered as such
15 with the commissioner. . . .

16 Revisor's Note

17 Section 2(a), V.T.I.C. Article 21.07-4, refers to
18 "an individual who is undergoing education and
19 training as an adjuster under the direction and
20 supervision of a licensed adjuster." The revised law
21 omits the references to "education" and "direction"
22 because, in the context in which the terms appear,
23 "education" is included in the meaning of "training,"
24 and "direction" is included in the meaning of
25 "supervision."

26 Revised Law

27 Sec. 4101.004. RECIPROCITY. The department may waive any
28 license requirement imposed under this chapter for an applicant who
29 holds a valid license from another state if the state has license
30 requirements substantially equivalent to the requirements for a
31 license issued under this chapter. (V.T.I.C. Art. 21.07-4, Sec.
32 4.)

33 Source Law

34 Sec. 4. The board may waive any license
35 requirement for an applicant with a valid license from
36 another state having license requirements
37 substantially equivalent to those of this state.

38 Revised Law

39 Sec. 4101.005. RULES. The commissioner may adopt rules

1 necessary to implement this chapter and to meet the minimum
2 requirements of federal law, including regulations. (V.T.I.C. Art.
3 21.07-4, Sec. 24.)

4 Source Law

5 Sec. 24. The commissioner may adopt rules
6 necessary to implement this Act and to meet the minimum
7 requirements of federal law and regulations.

8 Revised Law

9 Sec. 4101.006. ADVISORY BOARD. (a) An advisory board
10 shall make recommendations to the commissioner regarding:

11 (1) the scope, time, and conduct of written
12 examinations under Subchapter B;

13 (2) the times and locations in this state where the
14 examinations are held; and

15 (3) any other matter the commissioner submits to the
16 advisory board for a recommendation.

17 (b) The advisory board is composed of nine members appointed
18 by the commissioner as follows:

19 (1) the presiding officer of the unauthorized practice
20 of law committee of the State Bar of Texas;

21 (2) three members who represent the public;

22 (3) two members with knowledge and experience in the
23 profession of insurance adjusting;

24 (4) one member from a domestic insurer authorized to
25 engage in business in this state;

26 (5) one member from a foreign insurer authorized to
27 engage in business in this state; and

28 (6) one member who is an independent adjuster.

29 (c) A member who represents the public may not be:

30 (1) an officer, director, or employee of:

31 (A) an adjuster;

32 (B) an agent;

33 (C) a broker;

34 (D) an insurance agency;

35 (E) an insurer; or

1 (F) any other business entity regulated by the
2 department;

3 (2) a person required to register as a lobbyist under
4 Chapter 305, Government Code; or

5 (3) a person related to a person described by
6 Subdivision (1) or (2) within the second degree of affinity or
7 consanguinity.

8 (d) A member of the advisory board serves without
9 compensation. If authorized by the commissioner, an advisory board
10 member is entitled to reimbursement for reasonable expenses
11 incurred in attending meetings of the advisory board. (V.T.I.C.
12 Art. 21.07-4, Sec. 9.)

13 Source Law

14 Sec. 9. (a) The commissioner, with the
15 approval of the board, shall appoint an advisory board
16 to make recommendations to him with respect to the
17 scope, time and conduct of written examinations, and
18 the times and places within the state where they shall
19 be held, and such other matters as the commissioner may
20 submit to the board for their recommendations.

21 (b) The advisory board is composed of nine
22 members. Three members must be representatives of the
23 general public. The remaining members are the
24 chairman of the Joint Conference Committee on the
25 Unauthorized Practice of Law of the State Bar of Texas
26 and two members with knowledge and experience in the
27 insurance adjusting profession, one member from a
28 domestic insurance company authorized to do business
29 in Texas, one member from a foreign insurance company
30 licensed to do business in Texas, and one independent
31 adjusters.

32 (c) A public representative may not be:

33 (1) an officer, director, or employee of
34 an insurance company, insurance agency, agent, broker,
35 solicitor, adjuster, or any other business entity
36 regulated by the State Board of Insurance;

37 (2) a person required to register with the
38 secretary of state under Chapter 305, Government Code;
39 or

40 (3) related to a person described by
41 Subdivision (1) or (2) of this subsection within the
42 second degree of affinity or consanguinity.

43 (d) The members of the advisory board shall
44 serve without pay, but, upon authorization of the
45 commissioner, shall be reimbursed for their reasonable
46 expenses in attending meetings of the advisory board.

47 Revisor's Note

48 (1) Section 9(a), V.T.I.C. Article 21.07-4,
49 requires the commissioner to appoint advisory board
50 members "with the approval of the board," meaning the

1 State Board of Insurance. As explained in Revisor's
2 Note (3) to Section 4101.001, the State Board of
3 Insurance has been abolished. The revised law
4 accordingly omits the quoted language.

5 (2) Section 9(b), V.T.I.C. Article 21.07-4,
6 refers to the "Joint Conference Committee on the
7 Unauthorized Practice of Law." The revised law
8 substitutes "unauthorized practice of law committee"
9 because that is the correct name of the committee.
10 See, for example, Section 81.103, Government Code.

11 (3) Section 9(b), V.T.I.C. Article 21.07-4,
12 refers to an "insurance company licensed to do
13 business in Texas." The revised law substitutes
14 "authorized" for "licensed" because, under this code,
15 an insurer receives a certificate of authority
16 authorizing the insurer to engage in the business of
17 insurance rather than a license.

18 (4) Section 9(c)(1), V.T.I.C. Article 21.07-4,
19 prohibits "a solicitor" from serving as a public
20 representative on the advisory board. The revised law
21 omits the reference to "solicitor" because that term,
22 as it relates to a particular type of person engaged in
23 the business of insurance, was eliminated by Chapter
24 703, Acts of the 77th Legislature, Regular Session,
25 2001, and a person who performs the duties formerly
26 performed by a solicitor is now regulated as an
27 "agent."

28 (5) Section 9(c)(2), V.T.I.C. Article 21.07-4,
29 refers to a person "required to register with the
30 secretary of state under Chapter 305, Government
31 Code." The revised law omits the reference to the
32 secretary of state because under Chapter 304, Acts of
33 the 72nd Legislature, Regular Session, 1991, a person
34 formerly required to register with the secretary of

1 state must now register with the Texas Ethics
2 Commission under Chapter 305, Government Code. A
3 reference to the Texas Ethics Commission is
4 unnecessary because Chapter 305, Government Code,
5 provides for registration only with that agency.

6 [Sections 4101.007-4101.050 reserved for expansion]

7 SUBCHAPTER B. LICENSE REQUIREMENTS

8 Revised Law

9 Sec. 4101.051. LICENSE REQUIRED. Except as otherwise
10 provided by this chapter, a person may not act as or represent that
11 the person is an adjuster in this state unless the person holds a
12 license under this chapter. (V.T.I.C. Art. 21.07-4, Sec. 2(a)
13 (part).)

14 Source Law

15 Sec. 2. (a) No person shall act as or hold
16 himself out to be an adjuster in this state unless then
17 licensed therefor by this state,

18 Revised Law

19 Sec. 4101.052. APPLICATION. (a) An applicant for a
20 license under this chapter must submit to the department an
21 application on a form prescribed and provided by the department,
22 and include as part of or in connection with the application any
23 information that the department reasonably requires, including
24 information about the applicant's:

- 25 (1) identity;
26 (2) personal history;
27 (3) experience; and
28 (4) business record.

29 (b) The application must be accompanied by the fee required
30 by Section 4101.057. (V.T.I.C. Art. 21.07-4, Secs. 3, 14(b).)

31 Source Law

32 Sec. 3. Application for a license as an
33 insurance adjuster shall be made to the board upon
34 forms as prescribed and furnished by said board. As a
35 part of, or in connection with any such application,
36 the applicant shall furnish such information
37 concerning his identity, personal history,
38 experience, business record, and other pertinent facts

1 as said board may reasonably require.

2 [Sec. 14]

3 (b) The fees prescribed in Subsection (1) of
4 this section shall accompany the application for an
5 original license or a renewal thereof.

6 Revised Law

7 Sec. 4101.053. QUALIFICATIONS; ISSUANCE. (a) To qualify
8 for a license under this chapter, an applicant must:

9 (1) comply with this chapter;

10 (2) present evidence satisfactory to the department
11 that the applicant:

12 (A) is at least 18 years of age;

13 (B) resides in this state or a state or country
14 that permits a resident of this state to act as an adjuster in that
15 state or country;

16 (C) has complied with all federal laws relating
17 to employment or the transaction of business in the United States,
18 if the applicant does not reside in the United States;

19 (D) is trustworthy; and

20 (E) has had experience, special education, or
21 training of sufficient duration and extent regarding the handling
22 of loss claims under insurance contracts to make the applicant
23 competent to fulfill the responsibilities of an adjuster; and

24 (3) pass an examination conducted under this
25 subchapter or present evidence that the applicant has been exempted
26 under Section 4101.056.

27 (b) The commissioner shall issue a license to an applicant
28 who meets the qualifications prescribed by this section. (V.T.I.C.
29 Art. 21.07-4, Sec. 7.)

30 Source Law

31 Sec. 7. The commissioner shall license as an
32 insurance adjuster only an individual who has
33 otherwise complied with this Act, and who has
34 furnished evidence satisfactory to the board that:

35 (1) he is at least 18 years of age;

36 (2) he is a bona fide resident of this
37 state, or is a resident of a state or country which
38 will permit residents of this state to act as insurance
39 adjusters in such other state or country;

40 (3) if he is a nonresident of the United
41 States, he has complied with all federal laws

1 pertaining to employment or the transaction of
2 business in the United States;

3 (4) he is a trustworthy person;

4 (5) he has had experience or special
5 education or training with reference to the handling
6 of loss claims under insurance contracts of sufficient
7 duration and extent to make him competent to fulfill
8 the responsibilities of an insurance adjuster; and

9 (6) he has successfully passed an
10 examination as required by the commissioner in
11 accordance with this Act or has been exempted
12 according to the provisions of this Act.

13 Revisor's Note

14 (1) Section 7(2), V.T.I.C. Article 21.07-4,
15 refers to a "bona fide resident of this state." The
16 revised law omits "bona fide" as unnecessary because
17 the phrase does not add to the clear meaning of the
18 law. A person who does not actually reside in a state
19 is not a resident of that state.

20 (2) Section 7, V.T.I.C. Article 21.07-4, states
21 that an applicant must furnish evidence to the
22 commissioner that the applicant has "successfully
23 passed an examination as required by the
24 commissioner." The revised law omits "successfully"
25 and "as required by the commissioner" as unnecessary
26 because the meanings of the terms are implied by the
27 context in which the terms appear.

28 Revised Law

29 Sec. 4101.054. EXAMINATION REQUIRED. (a) To be eligible
30 for a license under this chapter, an applicant must personally take
31 and pass, to the satisfaction of the commissioner, a written
32 examination of the applicant's qualifications and competency.

33 (b) The department may supplement a written examination
34 under Subsection (a) with an oral examination.

35 (c) The commissioner shall prescribe each examination under
36 this section. An examination must be of sufficient scope to
37 reasonably test the applicant's knowledge relative to the kinds of
38 insurance that may be dealt with under the license and of:

39 (1) the duties of a licensed adjuster; and

40 (2) the laws of this state that apply to a licensed

1 adjuster.

2 (d) The commissioner may require a reasonable waiting
3 period before an applicant who fails to pass an examination is
4 eligible to be retested on a similar examination. (V.T.I.C. Art.
5 21.07-4, Secs. 10 (part), 11(a), 12(a), (c).)

6 Source Law

7 Sec. 10. Each applicant for a license as an
8 adjuster shall, prior to the issuance of such license,
9 personally take and pass, to the satisfaction of the
10 commissioner, an examination as a test of his
11 qualifications and competency; but

12 Sec. 11. (a) Each examination for a license as
13 an adjuster shall be as the board may prescribe and
14 shall be of sufficient scope reasonably to test the
15 applicant's knowledge relative to the kinds of
16 insurance which may be dealt with under the license
17 applied for, and of the duties and responsibilities
18 of, and laws of this state, applicable to such a
19 licensee.

20 Sec. 12. (a) The answers of the applicant to
21 any such examination shall be made in writing by the
22 applicant. Any such written examination may be
23 supplemented by oral examination.

24 (c) The commissioner may require a waiting time
25 of reasonable duration before giving a new examination
26 to an applicant who has failed to pass a previous
27 similar examination.

28 Revisor's Note

29 Section 11(a), V.T.I.C. Article 21.07-4, refers
30 to the "duties and responsibilities" of a licensed
31 adjuster. The revised law omits "responsibilities"
32 because, in context, "responsibilities" is included in
33 the meaning of "duties."

34 Revised Law

35 Sec. 4101.055. EXAMINATION PROCEDURES. (a) The department
36 shall prepare and make available to applicants instructions
37 specifying in general terms the subjects that may be covered in an
38 examination required under Section 4101.054.

39 (b) An examination under this subchapter shall be given at
40 times and locations in this state necessary to reasonably serve the
41 convenience of the department and applicants. (V.T.I.C. Art.
42 21.07-4, Secs. 11(b), 12(b).)

1 Source Law

2 [Sec. 11]

3 (b) The board shall prepare and make available
4 to applicants a manual or instructions specifying in
5 general terms the subjects which may be covered in any
6 examination for such a license.

7 [Sec. 12]

8 (b) The examination shall be given at such times
9 and places within this state as the board deems
10 necessary reasonably to serve the convenience of both
11 the commissioner and applicants.

12 Revisor's Note

13 Section 11(b), V.T.I.C. Article 21.07-4,
14 requires the department to provide to applicants "a
15 manual or instructions" outlining the possible
16 subjects of the examination. The revised law omits
17 "manual" because in the context in which the term
18 appears, "manual" is included in the definition of
19 "instructions."

20 Revised Law

21 Sec. 4101.056. EXEMPTION FROM EXAMINATION REQUIREMENT. (a)
22 An applicant for a license under this chapter is not required to
23 pass an examination under Section 4101.054 to receive the license
24 if the applicant:

25 (1) had been principally engaged in the investigation,
26 adjustment, or supervision of losses on August 27, 1973, and during
27 the 90-day period preceding that date;

28 (2) is applying for a renewal license under this
29 chapter;

30 (3) is licensed as an adjuster in another state with
31 which a reciprocal agreement has been entered into by the
32 commissioner; or

33 (4) has completed a course in adjusting losses as
34 prescribed and approved by the commissioner and it is certified to
35 the commissioner on completion of the course that the applicant
36 has:

37 (A) completed the course; and

38 (B) passed an examination testing the

1 applicant's knowledge and qualification, as prescribed by the
2 commissioner.

3 (b) An applicant wishing to claim an exemption under
4 Subsection (a)(4) is responsible for the scheduling and
5 administration of the examination required under that subsection.
6 (V.T.I.C. Art. 21.07-4, Secs. 10 (part), 12(d).)

7 Source Law

8 Sec. 10. . . . but the requirement of an
9 examination shall not apply to any of the following:

10 (1) an applicant who for the 90-day period
11 next preceding the effective date of this Act has been
12 principally engaged in the investigation, adjustment,
13 or supervision of losses and who is so engaged on the
14 effective date of this Act;

15 (2) an applicant for the renewal of a
16 license issued hereunder;

17 (3) an applicant who is licensed as an
18 insurance adjuster, as defined by this statute, in
19 another state with which state a reciprocal agreement
20 has been entered into by the commissioner; or

21 (4) any person who has completed a course
22 or training program in adjusting of losses as
23 prescribed and approved by the commissioner and is
24 certified to the commissioner upon completion of the
25 course that such person has completed said course or
26 training program, and has passed an examination
27 testing his knowledge and qualification, as prescribed
28 by the commissioner.

29 [Sec. 12]

30 (d) Scheduling and administration of
31 examinations by persons approved by the board pursuant
32 to Section 10(4) shall be effected by such persons.

33 Revisor's Note

34 (1) Section 10(1), V.T.I.C. Article 21.07-4,
35 exempts from the examination requirement a person who
36 was adjusting, investigating, or supervising losses
37 during a period preceding "the effective date of this
38 Act." The revised law replaces the quoted language
39 with "August 27, 1973," which was the effective date of
40 the act.

41 (2) Section 10(3), V.T.I.C. Article 21.07-4,
42 refers to an insurance adjuster, "as defined by this
43 statute." The revised law omits the quoted language as
44 unnecessary because the definitions in Section 1,
45 V.T.I.C. Article 21.07-4, revised as Section 4101.001,

1 apply throughout the chapter.

2 (3) Section 10(4), V.T.I.C. Article 21.07-4,
3 exempts an applicant for a license from the
4 examination requirement if the applicant completes a
5 "course or training program in adjusting of losses."
6 The revised law omits the term "training program"
7 because in the context in which the term appears,
8 "training program" is included in the definition of
9 "course."

10 Revised Law

11 Sec. 4101.057. FEES. (a) Before issuing or renewing a
12 license under this chapter, the department shall set and collect a
13 nonrefundable license fee in an amount not to exceed \$50.

14 (b) An applicant must remit the fee required by Subsection
15 (a) biennially after the issuance of the original license. If the
16 applicant's license has been expired for not more than 90 days, an
17 applicant for a renewal license must remit, in addition to the fee
18 assessed under Subsection (a), a fee equal to one-half of the
19 original license fee.

20 (c) Before administering an examination under this
21 subchapter, the department shall set and collect a nonrefundable
22 examination fee in an amount not to exceed \$50.

23 (d) Before issuing a duplicate license requested by an
24 adjuster, the department shall set and collect a duplicate license
25 fee.

26 (e) The department shall deposit a fee collected under this
27 chapter to the credit of the Texas Department of Insurance
28 operating account. (V.T.I.C. Art. 21.07-4, Secs. 14(a), (c), 23.)

29 Source Law

30 Sec. 14. (a) The commissioner shall collect in
31 advance the following nonrefundable fees for an
32 adjuster's license and examination:

33 (1) Insurance adjuster's license, each two
34 years, a fee in an amount not to exceed \$50 as
35 determined by the board, plus a fee equal to one-half
36 of the original license fee if the license is expired
37 for not more than 90 days; and

38 (2) For each examination, if given by the

1 board, a fee in an amount not to exceed \$50 as
2 determined by the board.

3 (c) When collected, the fees provided for by
4 this Act shall be deposited in the State Treasury to
5 the credit of the State Board of Insurance operating
6 fund; provided that no expenditure shall be made from
7 said fund except under authority of the Legislature as
8 set forth in the general appropriations bill.

9 Sec. 23. The department shall collect in
10 advance from an adjuster requesting a duplicate
11 license a fee in an amount determined by the
12 department.

13 Revisor's Note

14 (1) Section 14(c), V.T.I.C. Article 21.07-4,
15 requires fees collected under Section 14 to be
16 deposited in the state treasury to the credit of the
17 State Board of Insurance operating fund. Under the
18 authority of Chapter 4, Acts of the 72nd Legislature,
19 1st Called Session, 1991, that fund was converted to an
20 account in the general revenue fund. The revised law
21 is drafted accordingly.

22 (2) Section 14(c), V.T.I.C. Article 21.07-4,
23 requires that a fee collected be deposited in a fund in
24 the state treasury and that "no expenditure shall be
25 made from said fund except under authority of the
26 Legislature as set forth in the general appropriations
27 bill." The revised law omits the quoted language as
28 unnecessary because under Section 6, Article VIII,
29 Texas Constitution, money may not be drawn from the
30 treasury unless a specific appropriation is made.

31 Revised Law

32 Sec. 4101.058. LICENSE FORM. (a) The commissioner shall
33 prescribe the form of a license issued under this chapter.

34 (b) A license must contain:

- 35 (1) the adjuster's name;
- 36 (2) the address of the adjuster's place of business;
- 37 (3) the date of issuance and the date of expiration of
38 the license; and
- 39 (4) the name of the firm or insurer with whom the

1 adjuster is employed at the time the license is issued. (V.T.I.C.
2 Art. 21.07-4, Sec. 13.)

3 Source Law

4 Sec. 13. The commissioner shall prescribe the
5 form of the insurance adjuster's license. The license
6 shall contain:

7 (1) the name of the insurance adjuster and
8 the address of his place of business;

9 (2) date of issuance and date of
10 expiration of the license; and

11 (3) firm or insurer with whom insurance
12 adjuster is employed at time license is issued.

13 Revised Law

14 Sec. 4101.059. CONTINUING EDUCATION: GENERAL
15 REQUIREMENTS. (a) To renew a license under this chapter a licensed
16 adjuster must participate in a continuing education program
17 relating to consumer protection. The program must include
18 education relating to consumer protection laws, including:

19 (1) Chapter 541;

20 (2) Chapter 547;

21 (3) Subchapter A, Chapter 542;

22 (4) Subchapter E, Chapter 17, Business & Commerce
23 Code; and

24 (5) any other similar laws specified by the
25 department.

26 (b) The department may certify continuing education
27 programs. (V.T.I.C. Art. 21.07-4, Secs. 7A(a), (b).)

28 Source Law

29 Sec. 7A. (a) The board may adopt a procedure
30 for certifying and may certify continuing education
31 programs.

32 (b) Each adjuster, in order to renew a license
33 issued under this article, must participate in a
34 continuing education program relating to consumer
35 protection laws, including:

36 (1) Article 21.21, Insurance Code;

37 (2) the Unauthorized Insurers False
38 Advertising Process Act (Article 21.21-1, Vernon's
39 Texas Insurance Code);

40 (3) the Unfair Claim Settlement Practices
41 Act (Article 21.21-2, Insurance Code);

42 (4) the Deceptive Trade
43 Practices-Consumer Protection Act (Subchapter E,
44 Chapter 17, Business & Commerce Code); and

45 (5) analogous laws as specified by the
46 board.

1 of whether the applicant is:

2 (1) a resident of this state; or

3 (2) an otherwise licensed adjuster. (V.T.I.C. Art.
4 21.07-4, Sec. 5.)

5 Source Law

6 Sec. 5. In the event of a catastrophe or
7 emergency which arises out of a disaster, act of God,
8 riot, civil commotion, conflagration or other similar
9 occurrence, the commissioner shall, upon application,
10 issue an emergency license to persons who are
11 residents or nonresidents of this state and who may or
12 may not be otherwise licensed adjusters. Such
13 emergency license shall remain in force for a period
14 not to exceed 90 days, unless extended for an
15 additional period of 90 days by the commissioner. The
16 applicant must be certified by (i) a person licensed
17 under the provisions of this Act, or by (ii) an insurer
18 which maintains an office in this state and is licensed
19 to do business in this state. The licensed adjuster or
20 insurer who certifies said applicant under the
21 provisions of this section of this Act shall be
22 responsible for the loss or claims practices of the
23 emergency license holder.

24 Within five days of any applicant commencing work
25 as an adjuster hereunder, the employer of such
26 adjuster shall certify to the commissioner such
27 application without being deemed in violation of this
28 Act, provided that the commissioner may, after notice
29 and hearing, revoke said emergency license upon the
30 grounds as otherwise contained in this Act providing
31 for revocation of an adjuster's license.

32 The fee for an emergency license shall be in an
33 amount not to exceed \$20 as determined by the board and
34 shall be due and payable within 30 days of the issuance
35 of such emergency license.

36 Revisor's Note

37 Section 5, V.T.I.C. Article 21.07-4, refers to an
38 insurer "licensed to do business in this state." The
39 revised law substitutes "holds a certificate of
40 authority" for "licensed" for the reason stated in
41 Revisor's Note (3) to Section 4101.006.

42 Revised Law

43 Sec. 4101.102. LIMITED LICENSE. (a) If considered
44 necessary by the commissioner, the department may issue a limited
45 license to an applicant in the manner otherwise provided for the
46 issuance of a license under this chapter.

47 (b) The license shall specifically limit the kinds of
48 insurance that may be handled by the person.

1 (c) The person may not adjust claims in a kind of insurance
2 other than that for which the adjuster is specifically licensed.
3 (V.T.I.C. Art. 21.07-4, Secs. 8(a), (b), (c).)

4 Source Law

5 Sec. 8. (a) If the board considers it
6 necessary, a special insurance adjuster's license may
7 be issued under this Act to any license applicant in
8 the manner provided for the issuance of an insurance
9 adjuster's license.

10 (b) A special insurance adjuster's license shall
11 specifically limit the lines of insurance which may be
12 handled by the licensee.

13 (c) No person who is acting under a special
14 insurance adjuster's license may handle any other
15 lines of insurance other than those lines specified in
16 the license.

17 [Sections 4101.103-4101.150 reserved for expansion]

18 SUBCHAPTER D. POWERS AND DUTIES OF ADJUSTER

19 Revised Law

20 Sec. 4101.151. PLACE OF BUSINESS. (a) A licensed
21 adjuster shall maintain a place of business that is:

22 (1) located at the place at which the adjuster
23 principally conducts transactions under the license; and

24 (2) accessible to the public.

25 (b) A licensed adjuster shall promptly notify the
26 commissioner if the adjuster changes the location of the adjuster's
27 place of business. (V.T.I.C. Art. 21.07-4, Sec. 15.)

28 Source Law

29 Sec. 15. Every licensed adjuster shall have and
30 maintain a place of business accessible to the public.
31 Such place of business shall be located where the
32 adjuster principally conducts transactions under the
33 license. The licensee shall promptly notify the
34 commissioner of any change in the location of the place
35 of business.

36 Revised Law

37 Sec. 4101.152. REFERRAL BY INSURER. (a) An insurer may
38 not knowingly refer a claim or loss for adjustment in this state to
39 a person purporting to be or acting as an adjuster unless the person
40 holds a license under this chapter.

41 (b) Before referring a claim or loss for adjustment, an
42 insurer must ascertain from the commissioner whether the person

1 performing the adjustment holds a license under this chapter. Once
2 the insurer has ascertained that the person holds a license, the
3 insurer may refer the claim or loss to the person and may continue
4 to refer claims or losses to the person until the insurer has
5 knowledge or receives information from the commissioner that the
6 person no longer holds a license. (V.T.I.C. Art. 21.07-4, Sec. 6.)

7 Source Law

8 Sec. 6. (a) An insurer shall not knowingly
9 refer any claim or loss for adjustment in this state to
10 any person purporting to be or acting as an insurance
11 adjuster unless such person is currently licensed as
12 such as required in this Act.

13 (b) Prior to referring any such claim or loss,
14 the insurer shall ascertain from the commissioner
15 whether the proposed insurance adjuster is currently
16 licensed as such. Having once ascertained that a
17 particular person is so licensed, the insurer may
18 assume that such licensee will continue to be so
19 licensed until the insurer has knowledge, or receives
20 information from the commissioner, to the contrary.

21 [Sections 4101.153-4101.200 reserved for expansion]

22 SUBCHAPTER E. ENFORCEMENT

23 Revised Law

24 Sec. 4101.201. GROUNDS FOR DISCIPLINARY ACTION. (a) The
25 commissioner may discipline an adjuster or deny an application for
26 a license under this chapter under a department rule or any
27 applicable insurance law of this state.

28 (b) Department rules may specify grounds for discipline
29 that are comparable to grounds for discipline of other license
30 holders under this title. (V.T.I.C. Art. 21.07-4, Sec. 17.)

31 Source Law

32 Sec. 17. The department may discipline an
33 adjuster or deny an application under department rules
34 or any other applicable article of the Insurance Code
35 or another insurance law of this state. The rules may
36 specify grounds for discipline that are comparable to
37 grounds for discipline of other license holders under
38 this subchapter.

39 Revised Law

40 Sec. 4101.202. REINSTATEMENT OR REISSUANCE OF
41 LICENSE. The commissioner may not reinstate or reissue the license
42 of a license holder or former license holder whose license has been
43 suspended, revoked, or refused renewal until the commissioner

1 determines that the cause for a suspension, revocation, or refusal
2 of a license issued under this chapter no longer exists. (V.T.I.C.
3 Art. 21.07-4, Sec. 20.)

4 Source Law

5 Sec. 20. The commissioner shall not reinstate
6 the license of, or reissue a license to, any licensee
7 or former licensee, whose license has been suspended,
8 revoked or renewal thereof refused until the cause for
9 the suspension, revocation, or refusal of such license
10 is no longer existing and subject to the approval of
11 the commissioner.

12 Revised Law

13 Sec. 4101.203. CRIMINAL PENALTY. A person commits an
14 offense if the person violates Section 4101.051 or 4101.102(c). An
15 offense under this section is a misdemeanor punishable by:

16 (1) a fine of not more than \$500;

17 (2) confinement in the county jail for not more than
18 six months; or

19 (3) both the fine and the confinement. (V.T.I.C. Art.
20 21.07-4, Secs. 2(b), 8(d).)

21 Source Law

22 [Sec. 2]

23 (b) Any person who violates the provisions of
24 this section shall be guilty of a misdemeanor and, upon
25 conviction thereof, shall be punished by a fine of not
26 more than \$500, or by confinement in the county jail
27 for not more than six months, or by both such fine and
28 confinement.

29 [Sec. 8]

30 (d) Any person who violates the provisions of
31 Subsection (c) of this section is subject to the
32 penalty provided in Subsection (b) of Section 2 of this
33 Act.

34 Revisor's Note
35 (End of Chapter)

36 (1) Section 21, V.T.I.C. Article 21.07-4,
37 repeals all laws in conflict with that article. This
38 revision omits this provision as unnecessary because,
39 under general rules of statutory construction, a
40 statute automatically has the effect of repealing
41 prior conflicting enactments. The provision cannot
42 repeal subsequent legislation. The omitted law reads:

1 Sec. 21. All laws and parts of laws
2 in conflict with this Act are hereby
3 repealed. Upon the passage of this Act the
4 provisions of The Private Investigators and
5 Private Securities Agencies Act, as amended
6 (Article 4413 (29bb), Vernon's Texas Civil
7 Statutes), will have no applicability to
8 insurance adjusters licensed pursuant to
9 this Act. Article 19.01(3), Title 122-A,
10 Taxation--General, Revised Civil Statutes
11 of Texas, 1925, as amended, is hereby
12 expressly repealed.

13 (2) Section 22, V.T.I.C. Article 21.07-4,
14 provides that the article is severable. The revised
15 law omits the provision because it duplicates Section
16 311.032, Government Code (Code Construction Act).
17 Section 311.032 states that a provision of a statute is
18 severable from each other provision of the statute
19 that can be given effect. The omitted law reads:

20 Sec. 22. If any provisions of this
21 Act or the application thereof to any person
22 or circumstance is held invalid, such
23 invalidity shall not affect other
24 provisions or applications of the Act which
25 can be given effect without the invalid
26 provisions or application, and to this end
27 the provisions of this Act are declared to
28 be severable.

29 [Chapters 4102-4150 reserved for expansion]

30 SUBTITLE D. OTHER PROFESSIONALS

31 CHAPTER 4151. THIRD-PARTY ADMINISTRATORS

32 SUBCHAPTER A. GENERAL PROVISIONS

33	Sec. 4151.001.	DEFINITIONS	1922
34	Sec. 4151.002.	EXEMPTIONS	1924
35	Sec. 4151.003.	APPLICABILITY OF OTHER PROVISIONS OF CODE . .	1931
36	Sec. 4151.004.	APPLICABILITY TO CERTAIN INSURERS AND HEALTH 37 MAINTENANCE ORGANIZATIONS	1932
38	Sec. 4151.005.	ADMINISTRATOR NOT INSURANCE AGENT	1932
39	Sec. 4151.006.	RULES	1933

40 [Sections 4151.007-4151.050 reserved for expansion]

41 SUBCHAPTER B. CERTIFICATE OF AUTHORITY

42	Sec. 4151.051.	CERTIFICATE OF AUTHORITY REQUIRED	1933
43	Sec. 4151.052.	APPLICATION	1934
44	Sec. 4151.053.	APPROVAL OF APPLICATION.	1936

1	Sec. 4151.054.	DENIAL OF APPLICATION	1936
2	Sec. 4151.055.	FIDELITY BOND REQUIRED	1937
3	Sec. 4151.056.	DURATION OF CERTIFICATE OF AUTHORITY	1939
4	[Sections 4151.057-4151.100 reserved for expansion]		
5	SUBCHAPTER C. POWERS AND DUTIES OF THIRD-PARTY ADMINISTRATORS		
6	Sec. 4151.101.	WRITTEN AGREEMENT WITH INSURER OR PLAN	
7		SPONSOR REQUIRED	1939
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10		BY COMMISSIONER	1941
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13	Sec. 4151.106.	CERTAIN FUNDS COLLECTED OR RECEIVED BY	
14		ADMINISTRATOR	1943
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18	Sec. 4151.109.	PAYMENT OF CLAIMS FROM FIDUCIARY ACCOUNT	
19		PROHIBITED	1946
20	Sec. 4151.110.	UNDERWRITING STANDARDS	1946
21	Sec. 4151.111.	ADJUDICATION OF CLAIMS	1947
22	Sec. 4151.112.	MAINTENANCE OF BOOKS AND RECORDS.	1947
23	Sec. 4151.113.	ACCESS TO BOOKS AND RECORDS.	1948
24	Sec. 4151.114.	DISPOSITION OF BOOKS AND RECORDS ON	
25		TERMINATION OF WRITTEN AGREEMENT	1948
26	Sec. 4151.115.	CONFIDENTIALITY OF PERSONAL INFORMATION	1949
27	Sec. 4151.116.	ADVERTISING	1950
28	Sec. 4151.117.	COMPENSATION OF ADMINISTRATOR	1950
29	[Sections 4151.118-4151.150 reserved for expansion]		
30	SUBCHAPTER D. PHARMACY BENEFIT PLANS		
31	Sec. 4151.151.	DEFINITION	1951
32	Sec. 4151.152.	IDENTIFICATION CARDS	1951
33	Sec. 4151.153.	DISCLOSURE OF CERTAIN PATIENT INFORMATION	
34		PROHIBITED	1952

1 [Sections 4151.154-4151.200 reserved for expansion]

2 SUBCHAPTER E. REGULATION OF THIRD-PARTY ADMINISTRATORS

3 Sec. 4151.201. EXAMINATION OF ADMINISTRATOR. 1953
4 Sec. 4151.202. CONTENTS OF EXAMINATION; ON-SITE
5 EVALUATION 1954
6 Sec. 4151.203. COST OF EXAMINATION 1955
7 Sec. 4151.204. EXAMINATION UNDER OATH 1955
8 Sec. 4151.205. ANNUAL REPORT 1956
9 Sec. 4151.206. FEES. 1956
10 Sec. 4151.207. ADMINISTRATIVE SANCTIONS 1957
11 Sec. 4151.208. OFFENSE 1957

12 CHAPTER 4151. THIRD-PARTY ADMINISTRATORS

13 SUBCHAPTER A. GENERAL PROVISIONS

14 Revised Law

15 Sec. 4151.001. DEFINITIONS. In this chapter:

16 (1) "Administrator" means a person who, in connection
17 with annuities or life, health, and accident benefits, including
18 pharmacy benefits, collects premiums or contributions from or
19 adjusts or settles claims for residents of this state. The term
20 does not include a person described by Section 4151.002.

21 (2) "Insurer" means a person who engages in the
22 business of life, health, or accident insurance under the law of
23 this state.

24 (3) "Person" means an individual, partnership,
25 corporation, organization, government or governmental subdivision
26 or agency, business trust, estate trust, association, or any other
27 legal entity.

28 (4) "Plan" means a plan, fund, or program established,
29 adopted, or maintained by a plan sponsor or insurer to the extent
30 that the plan, fund, or program is established, adopted, or
31 maintained to provide indemnification or expense reimbursement for
32 any type of life, health, or accident benefit.

33 (5) "Plan sponsor" means a person, other than an
34 insurer, who establishes, adopts, or maintains a plan that covers

1 residents of this state, including a plan established, adopted, or
2 maintained by two or more employers or jointly by one or more
3 employers and one or more employee organizations, an association, a
4 committee, a joint board of trustees, or any similar group of
5 representatives who establish, adopt, or maintain a plan.
6 (V.T.I.C. Art. 21.07-6, Secs. 1(1) (part), (5), (6), (7), (8).)

7 Source Law

8 Art. 21.07-6

9 Sec. 1. In this article:

10 (1) "Administrator" means a person who
11 collects premiums or contributions from or who adjusts
12 or settles claims in connection with life, health, and
13 accident benefits, including pharmacy benefits, or
14 annuities for residents of this state but does not
15 include:

16 (5) "Insurer" or "insurance company" means
17 a person who transacts a life, health, or accident
18 insurance business under the law of this state.

19 (6) "Plan" means a plan, fund, or program
20 established, adopted, or maintained by a plan sponsor
21 or insurer to the extent that the plan, fund, or
22 program is established, adopted, or is maintained to
23 provide indemnification or expense reimbursement for
24 any type of life, health, or accident benefit.

25 (7) "Person" means an individual,
26 partnership, corporation, organization, government or
27 governmental subdivision or agency, business trust,
28 estate trust, association, or other legal entity.

29 (8) "Plan sponsor" means a person, other
30 than an insurer, who establishes, adopts, or maintains
31 a plan that covers residents of this state, including a
32 plan established, adopted, or maintained by two or
33 more employers or jointly by one or more employers and
34 one or more employee organizations, an association, a
35 committee, a joint board of trustees, or any similar
36 group of representatives who establish, adopt, or
37 maintain a plan.

38 Revisor's Note

39 (1) Section 1(5), V.T.I.C. Article 21.07-6,
40 defines "insurer" or "insurance company" to mean a
41 person who transacts a life, health, or accident
42 insurance business under the laws of this state. Since
43 under that definition, the terms "insurer" and
44 "insurance company" are synonymous, throughout this
45 chapter, "insurer" is substituted for "insurance
46 company" in the revised law.

47 (2) Section 1(3), V.T.I.C. Article 21.07-6,
48 defines "board" to mean the State Board of Insurance.

1 Chapter 685, Acts of the 73rd Legislature, Regular
2 Session, 1993, abolished the board and transferred its
3 functions to the commissioner of insurance and the
4 Texas Department of Insurance. Accordingly, the
5 revised law omits the definition as unnecessary.
6 Throughout this chapter, references to the board have
7 been changed appropriately. The omitted law reads:

8 (3) "Board" means the State
9 Board of Insurance.

10 (3) Section 1(4), V.T.I.C. Article 21.07-6,
11 defines "commissioner" to mean the commissioner of
12 insurance. The revised law omits this definition as
13 unnecessary because Chapter 31 of this code defines
14 "commissioner" for purposes of this code and the other
15 insurance laws of this state to mean the commissioner
16 of insurance. The omitted law reads:

17 (4) "Commissioner" means the
18 commissioner of insurance.

19 Revised Law

20 Sec. 4151.002. EXEMPTIONS. A person is not an
21 administrator if the person is:

22 (1) an employer acting on behalf of its employees or
23 the employees of one or more subsidiaries or affiliated
24 corporations of the employer;

25 (2) a union acting on behalf of its members;

26 (3) an insurer or a group hospital service corporation
27 subject to Chapter 842 acting with respect to a policy lawfully
28 issued and delivered by the insurer or corporation in and under the
29 law of a state in which the insurer or corporation was authorized to
30 engage in the business of insurance;

31 (4) a health maintenance organization that is
32 authorized to operate in this state under Chapter 843 with respect
33 to any activity that is specifically regulated under that chapter,
34 Chapter 1271, 1272, or 1367, or Subchapter A, Chapter 1452;

35 (5) an agent licensed under Subchapter B, Chapter

1 4054, who receives commissions as an agent and is acting:

2 (A) under appointment on behalf of an insurer
3 authorized to engage in the business of insurance in this state; and

4 (B) in the customary scope and duties of the
5 person's authority as an agent;

6 (6) a creditor acting on behalf of its debtor with
7 respect to insurance that covers a debt between the creditor and its
8 debtor, if the creditor performs only the functions of a group
9 policyholder or a creditor;

10 (7) a trust established in conformity with 29 U.S.C.
11 Section 186 or a trustee or employee who is acting under the trust;

12 (8) a trust that is exempt from taxation under Section
13 501(a), Internal Revenue Code of 1986, or a trustee or employee
14 acting under the trust;

15 (9) a custodian or a custodian's agent or employee who
16 is acting under a custodian account that complies with Section
17 401(f), Internal Revenue Code of 1986;

18 (10) a bank, credit union, savings and loan
19 association, or other financial institution that is subject to
20 supervision or examination under federal or state law by a federal
21 or state regulatory authority, if the institution is performing
22 only those functions for which the institution holds a license
23 under federal or state law;

24 (11) a company that advances and collects a premium or
25 charge from its credit card holders on their authorization, if the
26 company does not adjust or settle claims and acts only in the
27 company's debtor-creditor relationship with its credit card
28 holders;

29 (12) a person who adjusts or settles claims in the
30 normal course of the person's practice or employment as a licensed
31 attorney and who does not collect any premium or charge in
32 connection with annuities or with life, health, or accident
33 benefits, including pharmacy benefits;

34 (13) an adjuster licensed by the department who is

1 engaged in the performance of the person's powers and duties as an
2 adjuster in the scope of the person's license;

3 (14) a person who provides technical, advisory,
4 utilization review, precertification, or consulting services to an
5 insurer, plan, or plan sponsor but does not make any management or
6 discretionary decisions on behalf of the insurer, plan, or plan
7 sponsor;

8 (15) an attorney in fact for a Lloyd's plan operating
9 under Chapter 941 or for a reciprocal or interinsurance exchange
10 operating under Chapter 942 who is acting in the capacity of
11 attorney in fact under the applicable chapter;

12 (16) a joint fund, risk management pool, or
13 self-insurance pool composed of political subdivisions of this
14 state that participate in a fund or pool through interlocal
15 agreements, any nonprofit administrative agency or governing body
16 or other nonprofit entity that acts solely on behalf of a fund,
17 pool, agency, or body, or any other fund, pool, agency, or body
18 established under or for the purpose of implementing an interlocal
19 governmental agreement;

20 (17) a self-insured political subdivision;

21 (18) a plan under which insurance benefits are
22 provided exclusively by an insurer authorized to engage in the
23 business of insurance in this state and the administrator of which
24 is:

25 (A) a full-time employee of the plan's organizing
26 or sponsoring association, trust, or other entity; or

27 (B) a trustee of the organizing or sponsoring
28 trust; or

29 (19) a parent of a wholly owned direct or indirect
30 subsidiary insurer authorized to engage in the business of
31 insurance in this state or a wholly owned direct or indirect
32 subsidiary insurer that is a part of the parent's holding company
33 system that, under an agreement regulated and approved under
34 Chapter 823 or a similar statute of the domiciliary state if the

1 parent or subsidiary insurer is a foreign insurer engaged in
2 business in this state, on behalf of only itself or an affiliated
3 insurer:

4 (A) collects premiums or contributions, if the
5 parent or subsidiary insurer:

6 (i) prepares only billing statements and
7 places those statements in the United States mail; and

8 (ii) causes all collected premiums to be
9 deposited directly in a depository account of the particular
10 affiliated insurer; or

11 (B) furnishes proof-of-loss forms, reviews
12 claims, determines the amount of the liability for those claims,
13 and negotiates settlements, if the parent or subsidiary insurer
14 pays claims only from the funds of the particular subsidiary by
15 checks or drafts of that subsidiary. (V.T.I.C. Art. 21.07-6, Sec.
16 1(1) (part).)

17 Source Law

18 [Sec. 1. In this article:

19 (1) "Administrator" means a person who
20 collects premiums or contributions from or who adjusts
21 or settles claims in connection with life, health, and
22 accident benefits, including pharmacy benefits, or
23 annuities for residents of this state but does not
24 include:]

25 (A) an employer on behalf of its
26 employees or the employees of one or more subsidiaries
27 or affiliated corporations of the employer;

28 (B) a union on behalf of its members;

29 (C) an insurance company or a group
30 hospital service corporation subject to Chapter 20 of
31 this code with respect to a policy lawfully issued and
32 delivered by it in and under the law of a state in which
33 the insurer was authorized to do an insurance
34 business;

35 (D) a health maintenance
36 organization that is authorized to operate in this
37 state under the Texas Health Maintenance Organization
38 Act (Chapter 20A, Vernon's Texas Insurance Code), with
39 respect to any activity that is specifically regulated
40 under that Act;

41 (E) an agent licensed under Article
42 21.07 or Chapter 213, Acts of the 54th Legislature,
43 Regular Session, 1955 (Article 21.07-1, Vernon's Texas
44 Insurance Code), who is acting under appointment on
45 behalf of an insurance company authorized to do
46 business in this state and within the customary scope
47 and duties of the insurance agent's authority as an
48 agent and who receives commissions as an agent;

49 (F) a creditor who is acting on
50 behalf of its debtors with respect to insurance that

1 covers a debt between the creditor and its debtor so
2 long as only the functions of a group policyholder or
3 creditor are performed;

4 (G) a trust established in conformity
5 with 29 U.S.C. Section 186 and the trustees and
6 employees who are acting under the trust;

7 (H) a trust that is exempt from
8 taxation under Section 501(a) of the Internal Revenue
9 Code of 1986 and the trustees and employees acting
10 under the trust, or a custodian and the custodian's
11 agents and employees who are acting pursuant to a
12 custodian account that complies with Section 401(f),
13 Internal Revenue Code of 1986;

14 (I) a bank, credit union, savings and
15 loan association, or other financial institution that
16 is subject to supervision or examination under federal
17 or state law by federal or state regulatory
18 authorities so long as that institution is performing
19 only those functions for which it holds a license under
20 federal or state law;

21 (J) a company that advances and
22 collects a premium or charge from its credit card
23 holders on their authorization, if the company does
24 not adjust or settle claims and acts only in the
25 company's debtor-creditor relationship with its credit
26 card holders;

27 (K) a person who adjusts or settles
28 claims in the normal course of his practice or
29 employment as a licensed attorney and who does not
30 collect any premium or charge in connection with life,
31 health, or accident benefits, including pharmacy
32 benefits, or annuities;

33 (L) an adjuster licensed by the
34 commissioner, if the adjuster is engaged in the
35 performance of his powers and duties as an adjuster
36 within the scope of his license;

37 (M) a person who provides technical,
38 advisory, utilization review, precertification, or
39 consulting services to an insurer, plan, or plan
40 sponsor and who does not make any management or
41 discretionary decisions on behalf of an insurer, plan,
42 or plan sponsor;

43 (N) an attorney in fact for a Lloyd's
44 operating under Chapter 18 of this code or a reciprocal
45 or interinsurance exchange operating under Chapter 19
46 of this code if acting in the capacity of attorney in
47 fact under the applicable chapter;

48 (O) a municipality that is
49 self-insured or a joint fund, risk management pool, or
50 a self-insurance pool composed of political
51 subdivisions of this state that participate in a fund
52 or pool through interlocal agreements and any
53 nonprofit administrative agency or governing body or
54 any nonprofit entity that acts solely on behalf of a
55 fund, pool, agency, or body or any other funds, pools,
56 agencies, or bodies that are established pursuant to
57 or for the purpose of implementing an interlocal
58 governmental agreement;

59 (P) a self-insured political
60 subdivision;

61 (Q) a plan under which insurance
62 benefits are provided exclusively by a carrier
63 licensed to do business in this state and the
64 administrator of the plan is either:

65 (i) a full-time employee of the
66 plan's organizing or sponsoring association, trust, or
67 other entity; or

68 (ii) the trustee or trustees of

1 the organizing or sponsoring trust; or

2 (R) a parent of a wholly owned direct
3 or indirect subsidiary insurer licensed to do business
4 in this state or a wholly owned direct or indirect
5 subsidiary insurer that is a part of the parent's
6 holding company system that, only on behalf of itself
7 or its affiliated insurers:

8 (i) collects premiums or
9 contributions, if the parent or subsidiary insurer
10 prepares only billing statements, places those
11 statements in the United States mail, and causes all
12 collected premiums to be deposited directly in a
13 depository account of the particular affiliated
14 insurer, and the services rendered by the parent or
15 subsidiary are performed under an agreement regulated
16 and approved under Article 21.49-1 of this code or a
17 similar statute of the domiciliary state if the parent
18 or subsidiary is a foreign insurer doing business in
19 this state; or

20 (ii) furnishes proof-of-loss
21 forms, reviews claims, determines the amount of the
22 liability for those claims, and negotiates
23 settlements, but pays claims only from the funds of the
24 particular subsidiary by checks or drafts of that
25 subsidiary and the services rendered by the parent or
26 subsidiary are performed under an agreement regulated
27 and approved under Article 21.49-1 of this code or a
28 similar statute of the domiciliary state if the parent
29 or subsidiary is a foreign insurer doing business in
30 this state.

31 Revisor's Note

32 (1) Section 1(1)(D), V.T.I.C. Article 21.07-6,
33 excludes from the definition of "administrator" a
34 health maintenance organization "authorized to
35 operate in this state under the Texas Health
36 Maintenance Organization Act (Chapter 20A, Vernon's
37 Texas Insurance Code), with respect to any activity
38 that is specifically regulated under that Act." A
39 majority of V.T.I.C. Chapter 20A was revised in 2001 as
40 Chapter 843 of this code. The remaining portions of
41 Chapter 20A are revised in this code in Chapters 222
42 and 258, which impose premium and maintenance taxes on
43 health maintenance organizations; Chapter 1271, which
44 deals with benefits provided by health maintenance
45 organizations; Chapter 1272, which deals with
46 delegated networks; Chapter 1367, in part, which
47 requires health maintenance organizations to provide
48 coverage for certain childhood immunizations; and
49 Subchapter A, Chapter 1452, which deals with

1 credentialing of physicians and providers by health
2 maintenance organizations. Because a health
3 maintenance organization does not "operate under"
4 Chapters 222 and 258, and because the issue of taxes is
5 irrelevant to whether a health maintenance
6 organization engages in activities subject to
7 regulation under this chapter, the revised law does
8 not refer to Chapter 222 or 258 of this code.

9 (2) Section 1(1)(E), V.T.I.C. Article 21.07-6,
10 excludes from the definition of "administrator" a
11 person who is acting as and licensed as an agent under
12 "Article 21.07 or Chapter 213, Acts of the 54th
13 Legislature, Regular Session, 1955 (Article 21.07-1,
14 Vernon's Texas Insurance Code)." V.T.I.C. Article
15 21.07-6 was enacted by Chapter 1094, Acts of the 71st
16 Legislature, Regular Session, 1989. At that time,
17 V.T.I.C. Article 21.07 contained substantive
18 provisions related to the licensing of agents writing
19 life, accident, and health insurance, and V.T.I.C.
20 Article 21.07-1 contained substantive provisions
21 relating to the licensing of legal reserve life
22 insurance agents. Article 21.07 was substantially
23 revised by Chapter 703, Acts of the 77th Legislature,
24 Regular Session, 2001, and, as revised, contains
25 procedural provisions related to agent licensing but
26 does not itself authorize the licensing of any agents.
27 Chapter 703 also repealed Chapter 213, Acts of the 54th
28 Legislature, Regular Session, 1955 (V.T.I.C. Article
29 21.07-1) and added a new V.T.I.C. Article 21.07-1,
30 which authorizes the licensing of agents who write
31 life, accident, and health insurance, including legal
32 reserve life insurance, represent health maintenance
33 organizations, or write annuity contracts. Because
34 V.T.I.C. Article 21.07-6 is limited in its application

1 to administrators acting with regard to annuities or
2 life, accident, and health benefits, the exemption
3 provided by Section 1(1)(E) clearly applies only to an
4 agent licensed to write annuity contracts or life,
5 accident, or health insurance. Accordingly, the
6 revised law refers only to Subchapter B, Chapter 4054,
7 of this code, which is the revision of the relevant
8 portion of Article 21.07-1 as added by Chapter 703.

9 (3) Section 1(1)(O), V.T.I.C. Article 21.07-6,
10 in part excludes from the definition of
11 "administrator" a "municipality that is
12 self-insured." Section 1(1)(P), V.T.I.C. Article
13 21.07-6, revised in this section, excludes from the
14 definition of "administrator" a "self-insured
15 political subdivision." A municipality is a political
16 subdivision. Accordingly, the revised law omits the
17 reference to a "municipality that is self-insured"
18 because the term "self-insured political subdivision"
19 includes a "municipality that is self-insured."

20 (4) Section 1(1)(Q), V.T.I.C. Article 21.07-6,
21 excludes from the definition of "administrator" a plan
22 under which insurance benefits are provided
23 exclusively by "a carrier licensed to do business in
24 this state." Similarly, Section 1(1)(R), V.T.I.C.
25 Article 21.07-6, excludes from the definition of
26 "administrator" a parent of a wholly owned direct or
27 indirect subsidiary insurer "licensed to do business
28 in this state." The revised law substitutes
29 "authorized to engage in" for "licensed to do" because
30 under this code an insurer is issued a certificate of
31 authority to engage in business in this state.

32 Revised Law

33 Sec. 4151.003. APPLICABILITY OF OTHER PROVISIONS OF
34 CODE. An administrator is subject to Section 823.457, Subchapter H

1 of Chapter 101, Chapter 541, Subchapter A of Chapter 542, and
2 Chapter 804. (V.T.I.C. Art. 21.07-6, Sec. 23.)

3 Source Law

4 Sec. 23. An administrator is subject to
5 Articles 1.36, 21.21, and 21.21-2, of this code.

6 Revised Law

7 Sec. 4151.004. APPLICABILITY TO CERTAIN INSURERS AND HEALTH
8 MAINTENANCE ORGANIZATIONS. An insurer or health maintenance
9 organization that is not exempt under Section 4151.002(3) or (4) is
10 subject to all provisions of this chapter other than Sections
11 4151.005, 4151.051-4151.054, 4151.056, and 4151.206(a)(1).
12 (V.T.I.C. Art. 21.07-6, Sec. 24.)

13 Source Law

14 Sec. 24. An insurer or health maintenance
15 organization that is not exempt under Section 1(1)(C)
16 or (D) of this article is subject to all provisions of
17 this article, except Sections 3, 4, 5, 10, and
18 20(a)(1).

19 Revised Law

20 Sec. 4151.005. ADMINISTRATOR NOT INSURANCE AGENT. (a) An
21 administrator licensed in any state who accepts an agent's
22 commission for coverage for a risk located in this state and
23 disburses that commission to an agent in this state is not
24 considered an agent for purposes of this state's laws relating to
25 the licensing of agents.

26 (b) The exemption provided by this section does not
27 authorize an administrator to perform any other act for which a
28 license as an agent is required by law. (V.T.I.C. Art. 21.07-6,
29 Sec. 10.)

30 Source Law

31 Sec. 10. An administrator licensed in any state
32 that accepts agent's commissions for coverage for
33 risks located in this state and disburses those
34 commissions to licensed agents in this state is not
35 considered an insurance agent for purposes of this
36 state's insurance agent licensing laws. The exemption
37 provided by this section does not authorize an
38 administrator to perform any other acts for which a
39 license as an insurance agent is required by law.

1 Revisor's Note

2 Section 10, V.T.I.C. Article 21.07-6, refers to
3 "licensed agents in this state" and to an "insurance
4 agent." The revised law omits "licensed" as
5 unnecessary because under Section 2, V.T.I.C. Article
6 21.01, which is revised as Section 4001.101 of this
7 code, a person may not act as an agent in this state
8 unless the person holds a license or certificate of
9 authority. The revised law substitutes "agent" for
10 "insurance agent" because "agent" is the defined term
11 used in this title. See Section 4001.003 of this code.

12 Revised Law

13 Sec. 4151.006. RULES. The commissioner may adopt fair and
14 reasonable rules, minimum standards, or limitations as appropriate
15 to augment and implement this chapter. (V.T.I.C. Art. 21.07-6,
16 Sec. 2.)

17 Source Law

18 Sec. 2. The board may establish and promulgate
19 rules, regulations, minimum standards, or limitations
20 that are fair and reasonable as may be appropriate for
21 the augmentation and implementation of this article.

22 Revisor's Note

23 Section 2, V.T.I.C. Article 21.07-6, provides
24 that the State Board of Insurance may establish and
25 promulgate "rules, regulations, minimum standards, or
26 limitations." The revised law omits the reference to
27 "regulations" because under Section 311.005(5),
28 Government Code (Code Construction Act), a rule is
29 defined to include a regulation. That definition
30 applies to the revised law.

31 [Sections 4151.007-4151.050 reserved for expansion]

32 SUBCHAPTER B. CERTIFICATE OF AUTHORITY

33 Revised Law

34 Sec. 4151.051. CERTIFICATE OF AUTHORITY REQUIRED. (a) An
35 individual, corporation, organization, trust, partnership, or

1 other legal entity may not act as or hold itself out as an
2 administrator unless the entity is covered by and is engaging in
3 business under a certificate of authority issued under this
4 chapter.

5 (b) An administrator is required to hold only one
6 certificate of authority issued under this chapter. (V.T.I.C. Art.
7 21.07-6, Secs. 3(a), (b).)

8 Source Law

9 Sec. 3. (a) An individual, corporation,
10 organization, trust, partnership, or other legal
11 entity may not act as or hold itself out as an
12 administrator unless it is covered by and is doing
13 business under a certificate of authority issued under
14 this article.

15 (b) Each administrator is required to have only
16 one certificate of authority issued under this
17 article.

18 Revised Law

19 Sec. 4151.052. APPLICATION. An application for a
20 certificate of authority to engage in business as an administrator
21 must be in a form prescribed by the commissioner and must include
22 the following:

23 (1) a copy of each basic organizational document of
24 the applicant, including the articles of incorporation, bylaws,
25 articles of association, trade name certificate, and any other
26 similar document and a copy of any amendment to any of those
27 documents;

28 (2) a description of the applicant and the applicant's
29 services, facilities, and personnel;

30 (3) if the applicant is not domiciled in this state, a
31 power of attorney executed by the applicant appointing the
32 commissioner, the commissioner's successors in office, or the
33 commissioner's appointed designee as the applicant's attorney in
34 this state on whom process may be served in any legal action or
35 proceeding based on a cause of action arising in this state against
36 the applicant;

37 (4) an audited financial statement of the applicant
38 covering the preceding three calendar years or any lesser period

1 that the applicant and any predecessors of the applicant have been
2 in existence, or if an audited financial statement is not
3 available, an unaudited financial statement as of a date not
4 earlier than the 120th day before the date the application is filed,
5 accompanied by an affidavit or certification of the applicant that:

6 (A) the unaudited financial statement is true and
7 correct, as of its date; and

8 (B) a material change in financial condition has
9 not occurred from the date of the financial statement to the
10 execution date of the affidavit or certification; and

11 (5) any other information the commissioner reasonably
12 requires. (V.T.I.C. Art. 21.07-6, Sec. 4.)

13 Source Law

14 Sec. 4. An application for a certificate of
15 authority to operate as an administrator must be in a
16 form prescribed by the commissioner and must include
17 the following:

18 (1) copies of all basic organizational
19 documents of the administrator, including the articles
20 of incorporation, bylaws, articles of association,
21 trade name certificate, and other similar documents
22 and copies of all amendments to those documents;

23 (2) a description of the administrator and
24 its services, facilities, and personnel;

25 (3) a power of attorney executed by the
26 administrator, if not domiciled in this state,
27 appointing the commissioner, the commissioner's
28 successors in office, or the commissioner's duly
29 appointed designee as the attorney of the
30 administrator in this state, on whom process may be
31 served in any legal action or proceeding based on a
32 cause of action arising in this state against the
33 administrator;

34 (4) an audited financial statement of the
35 applicant covering the preceding three calendar years
36 or for any lesser period that the applicant and any
37 predecessors of the applicant have been in existence,
38 but if an audited financial statement is not
39 available, the applicant shall attach an unaudited
40 financial statement as of a date not earlier than the
41 120th day before the date the application is filed,
42 accompanied by an affidavit or certification of the
43 applicant that:

44 (A) the unaudited financial
45 statement is true and correct, as of its date; and

46 (B) no material change in financial
47 condition has occurred from the date of the financial
48 statement to the execution date of the affidavit or
49 certification; and

50 (5) any other information the commissioner
51 may reasonably require.

1 Revised Law

2 Sec. 4151.053. APPROVAL OF APPLICATION. The commissioner
3 shall approve an application for a certificate of authority to
4 engage in business in this state as an administrator if the
5 commissioner is satisfied that:

6 (1) granting the application would not violate a
7 federal or state law;

8 (2) the financial condition of the applicant or of
9 each person who would operate or control the applicant is such that
10 granting a certificate of authority would not be adverse to the
11 public interest;

12 (3) the applicant has not attempted to obtain the
13 certificate of authority through fraud or bad faith;

14 (4) the applicant has complied with this chapter and
15 rules adopted by the commissioner under this chapter; and

16 (5) the name under which the applicant will engage in
17 business in this state is not so similar to that of another
18 administrator or insurer that it is likely to mislead the public.
19 (V.T.I.C. Art. 21.07-6, Sec. 5(a).)

20 Source Law

21 Sec. 5. (a) The commissioner shall approve an
22 application for a certificate of authority to conduct
23 a business in this state as an administrator if the
24 commissioner is satisfied that the application meets
25 the following criteria:

26 (1) the granting of the application would
27 not violate a federal or state law;

28 (2) the financial condition of an
29 administrator applicant or those persons who would
30 operate or control an administrator applicant are such
31 that the granting of a certificate of authority would
32 not be adverse to the public interest;

33 (3) the applicant has not attempted
34 through fraud or bad faith to obtain the certificate of
35 authority;

36 (4) the applicant has complied with this
37 article and rules adopted by the board under this
38 article; and

39 (5) the name under which the applicant
40 will conduct business in this state is not so similar
41 to that of another administrator or insurer that it is
42 likely to mislead the public.

43 Revised Law

44 Sec. 4151.054. DENIAL OF APPLICATION. (a) If the

1 commissioner is unable to approve an application for a certificate
2 of authority, the commissioner shall:

3 (1) provide the applicant with written notice
4 specifying each deficiency in the application; and

5 (2) offer the applicant the opportunity for a hearing
6 to address each reason and circumstance for possible denial of the
7 application.

8 (b) The commissioner must provide an opportunity for a
9 hearing before the commissioner finally denies an application.

10 (c) At the hearing, the applicant has the burden to produce
11 sufficient competent evidence on which the commissioner can make
12 the determinations required by Section 4151.053. (V.T.I.C. Art.
13 21.07-6, Sec. 5(b).)

14 Source Law

15 (b) If the commissioner is unable to approve the
16 application for a certificate of authority, he shall
17 provide the applicant with written notice detailing
18 all deficiencies in the application and offer the
19 applicant the opportunity for a hearing to address the
20 reasons and circumstances for possible denial. The
21 opportunity for hearing must be provided before the
22 commissioner finally denies an application. The
23 applicant has the burden, at the hearing, to produce
24 sufficient competent evidence on which the
25 commissioner can make the findings provided by
26 Subsection (a) of this section.

27 Revised Law

28 Sec. 4151.055. FIDELITY BOND REQUIRED. (a) If the
29 commissioner approves an application for a certificate of
30 authority, before the commissioner issues the certificate of
31 authority, the applicant must:

32 (1) obtain and maintain a fidelity bond that complies
33 with this section; and

34 (2) submit to the commissioner proof that the
35 applicant has obtained the fidelity bond.

36 (b) The fidelity bond must protect against an act of fraud
37 or dishonesty by the applicant in exercising the applicant's powers
38 and duties as administrator.

39 (c) The fidelity bond may not be less than \$10,000 and may

1 not be more than the lesser of:

2 (1) 10 percent of the amount of funds handled during
3 the preceding year or, if no funds were handled during the preceding
4 year, 10 percent of the amount of funds reasonably estimated to be
5 handled by the administrator during the current calendar year; or

6 (2) \$500,000.

7 (d) On written request by an administrator for reduction of
8 the amount of the fidelity bond for a particular year, the
9 commissioner may authorize the reduction of the amount of the bond
10 if the administrator presents evidence that the amount of funds to
11 be handled during that year will be less than the amount handled
12 during the preceding year.

13 (e) For purposes of this section, the amount of funds
14 handled by a person in the person's capacity as administrator is
15 either the total amount of premiums and contributions received by
16 the administrator or the total amount of benefits paid by the
17 administrator, whichever is greater, during the preceding calendar
18 year in all jurisdictions in which the person acts as an
19 administrator.

20 (f) Unless the administrator and the insurer or plan agree
21 otherwise in writing, an administrator is required to obtain and
22 maintain only one fidelity bond for all insurers and plans for which
23 the administrator acts as administrator in this state. (V.T.I.C.
24 Art. 21.07-6, Sec. 6.)

25 Source Law

26 Sec. 6. (a) Each person whose application for
27 a certificate of authority is approved by the
28 commissioner under this article must obtain and
29 maintain a fidelity bond and must submit to the
30 commissioner proof that a fidelity bond that complies
31 with this section has been obtained before the
32 commissioner issues the certificate of authority.

33 (b) The amount of the bond may not be less than
34 \$10,000. The amount of the bond may not be more than 10
35 percent of the amount of total funds handled during the
36 previous year or, if no funds were handled during the
37 preceding year, 10 percent of the amount of funds
38 reasonably estimated to be handled during the current
39 calendar year by the administrator; however, in no
40 case may the amount of the bond be more than \$500,000.

41 (c) On written request of an administrator for
42 reduction of the amount of the fidelity bond for a

1 particular year, the commissioner may authorize the
2 reduction of the amount of the bond if the
3 administrator presents evidence that the amount of
4 funds to be handled during that particular year will be
5 less than the amount handled in the preceding year.

6 (d) For purposes of this section, the amount of
7 total funds handled by a person in his capacity as
8 administrator shall include either the total amount of
9 premiums and contributions received by the
10 administrator or the total amount of benefits paid by
11 the administrator, whichever is greater, during the
12 preceding calendar year in all jurisdictions in which
13 he acts as an administrator.

14 (e) The fidelity bond shall protect against acts
15 of fraud or dishonesty by the administrator in
16 carrying out his powers and duties as administrator.

17 (f) An administrator is required to obtain and
18 maintain only one fidelity bond for all insurers and
19 plans for which the administrator acts as
20 administrator in this state unless the administrator
21 and the insurer or plan agree otherwise in writing.

22 Revised Law

23 Sec. 4151.056. DURATION OF CERTIFICATE OF AUTHORITY. A
24 certificate of authority issued to an administrator under this
25 chapter is effective until it is suspended, canceled, or revoked.
26 The issuance, denial, suspension, cancellation, or revocation of a
27 certificate of authority to act as an administrator is subject to:

28 (1) Subchapters B and C, Chapter 4005; and

29 (2) Chapter 82. (V.T.I.C. Art. 21.07-6, Sec. 3(c).)

30 Source Law

31 (c) The certificate of authority issued under
32 this article shall continue in effect until suspended,
33 canceled, or revoked. The issuance, denial,
34 suspension, cancellation, or revocation of a
35 certificate of authority to act as an administrator is
36 subject to:

37 (1) Sections 2A, 3A, 4A, 5A, and 6A,
38 Article 21.01-2, of this code; and

39 (2) Chapter 82 of this code.

40 [Sections 4151.057-4151.100 reserved for expansion]

41 SUBCHAPTER C. POWERS AND DUTIES OF THIRD-PARTY ADMINISTRATORS

42 Revised Law

43 Sec. 4151.101. WRITTEN AGREEMENT WITH INSURER OR PLAN
44 SPONSOR REQUIRED. An administrator may provide services only
45 under a written agreement with an insurer or plan sponsor.
46 (V.T.I.C. Art. 21.07-6, Sec. 11(a).)

47 Source Law

48 Sec. 11. (a) An administrator may provide
49 services only pursuant to a written agreement with an

1 insurer or plan sponsor.

2 Revised Law

3 Sec. 4151.102. CONTENTS OF WRITTEN AGREEMENT. (a) The
4 written agreement must include each requirement prescribed by this
5 subchapter except for a requirement that does not apply to any
6 function the administrator performs.

7 (b) If a policy or plan document is issued to a trustee, a
8 copy of the trust agreement and any amendment to that trust
9 agreement becomes part of the written agreement.

10 (c) The written agreement may not contain a provision that
11 unreasonably restricts the availability to a plan participant of an
12 individual life, health, or accident policy or annuity through an
13 agent selected by the plan participant. (V.T.I.C. Art. 21.07-6,
14 Secs. 11(d), (e), (f).)

15 Source Law

16 (d) The written agreement shall include the
17 requirements provided by Sections 12 through 19 of
18 this article except for requirements that do not apply
19 to functions performed by the administrator.

20 (e) If a policy or plan document is issued to a
21 trustee, a copy of the trust agreement and any
22 amendment to that trust agreement becomes part of the
23 written agreement required by this section.

24 (f) The written agreement required by this
25 section may not contain a provision that unreasonably
26 restricts the right of a plan participant to the
27 availability of individual life, health, or accident
28 policies or annuities through an agent selected by the
29 plan participant.

30 Revisor's Note

31 Section 11(f), V.T.I.C. Article 21.07-6, refers
32 to "the written agreement required by this section."
33 Throughout this subchapter, the revised law omits
34 "required by this section," "required by this
35 article," and similar phrases in connection with the
36 written agreement between an administrator and an
37 insurer or plan sponsor because it is clear that
38 "written agreement" means the written agreement
39 required by Section 11(a), V.T.I.C. Article 21.07-6,
40 which is revised as Section 4151.101.

1 Revised Law

2 Sec. 4151.103. RETENTION OF WRITTEN AGREEMENT; INSPECTION
3 BY COMMISSIONER. (a) During the term of the written agreement,
4 the administrator and the insurer, plan, or plan sponsor shall
5 retain a copy of the agreement as part of their official records.

6 (b) On written request by the commissioner, the
7 administrator shall make the written agreement available for
8 inspection by the commissioner or the commissioner's designee.

9 (c) Information the commissioner or the commissioner's
10 designee obtains from the written agreement is confidential and may
11 not be made available to the public. An employee of the department
12 may examine the information in exercising powers and performing
13 duties under this chapter. (V.T.I.C. Art. 21.07-6, Secs. 11(b),
14 (c).)

15 Source Law

16 (b) The administrator and the insurer, plan, or
17 plan sponsor shall retain a copy of the written
18 agreement as part of their official records for the
19 term of the agreement, and on written request of the
20 commissioner, the administrator shall make the written
21 agreement available for inspection by the commissioner
22 or his designated representative.

23 (c) Information obtained by the commissioner or
24 the commissioner's designated representative from the
25 written agreement is confidential and may not be made
26 available to the public. The information may be
27 examined by employees of the board and the
28 commissioner in carrying out functions under this
29 article.

30 Revised Law

31 Sec. 4151.104. NOTICE OF USE OF ADMINISTRATOR'S SERVICES.
32 If an insurer, plan, or plan sponsor uses the services of an
33 administrator, the administrator shall give written notice to each
34 insured or plan participant of the administrator's identity and the
35 relationship among the administrator and the insurer, plan, or plan
36 sponsor and the insured or plan participant. The insurer, plan, or
37 plan sponsor must approve the notice before the notice is
38 distributed. (V.T.I.C. Art. 21.07-6, Sec. 13(a).)

39 Source Law

40 Sec. 13. (a) If the services of an
41 administrator are used, the administrator shall give

1 written notice to insureds or plan participants of the
2 identity of the administrator and the relationship
3 among the administrator and the insurer, plan, or plan
4 sponsor and the insured or plan participant. The
5 notice must be approved by the insurer, plan, or plan
6 sponsor before distribution.

7 Revised Law

8 Sec. 4151.105. PAYMENTS TO ADMINISTRATOR. (a) If an
9 insurer, plan, or plan sponsor uses the services of an
10 administrator:

11 (1) a payment of a premium or contribution to the
12 administrator by or on behalf of an insured or plan participant is
13 considered to have been received by the insurer, plan, or plan
14 sponsor; and

15 (2) a payment of a return premium, contribution, or
16 claim to the administrator by the insurer, plan, or plan sponsor is
17 not considered payment to the insured, plan participant, or
18 claimant until the insured, plan participant, or claimant receives
19 the payment.

20 (b) This section does not limit a right of an insurer, plan,
21 or plan sponsor against the administrator resulting from the
22 administrator's failure to make a payment to an insured, plan
23 participant, or claimant. (V.T.I.C. Art. 21.07-6, Sec. 12.)

24 Source Law

25 Sec. 12. (a) If an insurer, plan, or plan
26 sponsor uses the services of an administrator under a
27 written agreement as required by Section 11 of this
28 article, the payment of premiums or contributions to
29 the administrator by or on behalf of an insured or plan
30 participant is considered to have been received by the
31 insurer, plan, or plan sponsor, and payment of return
32 premium, contributions, or claims by the insurer,
33 plan, or plan sponsor to the administrator are not
34 considered payment to the insured, plan participant,
35 or claimant until the payments are received by the
36 insured, plan participant, or claimant.

37 (b) This section does not limit a right of an
38 insurer, plan, or plan sponsor against the
39 administrator resulting from the administrator's
40 failure to make payments to insureds, plan
41 participants, or claimants.

42 Revisor's Note

43 Section 12(a), V.T.I.C. Article 21.07-6, refers
44 to an insurer, plan, or plan sponsor that uses the
45 services of an administrator "under a written

1 agreement as required by Section 11 of this article."
2 The revised law omits the quoted language as
3 unnecessary. Section 11(a), V.T.I.C. Article 21.07-6,
4 which is revised as Section 4151.101, clearly provides
5 that an administrator may provide services only under
6 a written agreement with an insurer or plan sponsor.

7 Revised Law

8 Sec. 4151.106. CERTAIN FUNDS COLLECTED OR RECEIVED BY
9 ADMINISTRATOR. (a) An administrator who collects funds must
10 identify and state separately in writing the amount of any premium
11 or contribution specified by the insurer, plan, or plan sponsor for
12 the coverage and provide the information to any person who pays to
13 the administrator a premium or contribution.

14 (b) An administrator holds in a fiduciary capacity:

15 (1) a premium or contribution the administrator
16 collects on behalf of an insurer, plan, or plan sponsor; and

17 (2) a return premium the administrator receives from
18 an insurer, plan, or plan sponsor. (V.T.I.C. Art. 21.07-6, Secs.
19 13(b), 17(a).)

20 Source Law

21 [Sec. 13]

22 (b) If an administrator collects funds, the
23 administrator must identify and state separately in
24 writing the amount of any premium or contribution
25 specified by the insurer, plan, or plan sponsor for the
26 coverage and must give this written information to any
27 person who pays to the administrator a premium or
28 contribution.

29 Sec. 17. (a) Premiums and contributions
30 collected by an administrator on behalf of or for an
31 insurer, plan, or plan sponsor and return premiums
32 received from an insurer, plan, or plan sponsor are
33 held by the administrator in a fiduciary capacity.

34 Revisor's Note

35 Section 17(a), V.T.I.C. Article 21.07-6, refers
36 to "[p]remiums and contributions collected by an
37 administrator on behalf of or for an insurer, plan, or
38 plan sponsor." Throughout this subchapter, the
39 revised law omits "or for" from the phrase "on behalf

1 of or for" because the concept of collecting funds
2 "for" an insurer, plan, or plan sponsor is included
3 within the meaning of collecting funds "on behalf of"
4 an insurer, plan, or plan sponsor.

5 Revised Law

6 Sec. 4151.107. DELIVERY OR DEPOSIT OF CERTAIN FUNDS
7 RECEIVED BY ADMINISTRATOR. (a) On receiving a premium,
8 contribution, or return premium, an administrator shall:

9 (1) timely deliver the funds to the person entitled to
10 the funds according to terms of the written agreement; or

11 (2) promptly deposit the funds in a fiduciary bank
12 account established and maintained by the administrator.

13 (b) If premiums or contributions deposited in a fiduciary
14 bank account were collected on behalf of more than one insurer,
15 plan, or plan sponsor, the administrator shall:

16 (1) maintain records that clearly record separately
17 the deposits to and withdrawals from the account on behalf of each
18 insurer, plan, or plan sponsor; and

19 (2) on request of an insurer, plan, or plan sponsor,
20 provide to the insurer, plan, or plan sponsor a copy of the records
21 relating to deposits and withdrawals on behalf of that insurer or
22 plan.

23 (c) The requirements of Subsection (b):

24 (1) are in addition to requirements of any other
25 federal or state law; and

26 (2) do not authorize the commingling of funds if
27 otherwise prohibited by law. (V.T.I.C. Art. 21.07-6, Secs. 17(b),
28 (c).)

29 Source Law

30 (b) On receipt of premiums, contributions, or
31 return premiums, the administrator shall:

32 (1) timely remit the funds to the person
33 entitled to them according to terms of the written
34 agreement; or

35 (2) promptly deposit the funds in a
36 fiduciary bank account established and maintained by
37 the administrator.

38 (c) If premiums or contributions deposited in a

1 fiduciary bank account were collected on behalf of or
2 for more than one insurer, plan, or plan sponsor, the
3 administrator shall keep records that clearly record
4 separately the deposits and withdrawals from the
5 account on behalf of or for each insurer, plan, or plan
6 sponsor. The administrator shall obtain and maintain
7 copies of these records, and on request of an insurer,
8 plan, or plan sponsor, the administrator shall furnish
9 to the insurer, plan, or plan sponsor copies of the
10 records relating to deposits and withdrawals on behalf
11 of or for that insurer or plan. The requirements of
12 this subsection are in addition to requirements of any
13 other federal or state law and do not authorize the
14 commingling of funds if otherwise prohibited by law.

15 Revisor's Note

16 Section 17(c), V.T.I.C. Article 21.07-6,
17 requires an administrator that deposits in a fiduciary
18 bank account premiums or contributions that were
19 collected on behalf of more than one insurer, plan, or
20 plan sponsor, to "keep records that clearly record
21 separately the deposits and withdrawals from the
22 account on behalf of or for each insurer, plan, or plan
23 sponsor" and to "obtain and maintain copies of these
24 records." The revised law omits the requirement to
25 "obtain and maintain copies of these records" because
26 that duty is included within the requirement that an
27 administrator "keep" those records.

28 Revised Law

29 Sec. 4151.108. WITHDRAWALS FROM FIDUCIARY ACCOUNT. A
30 withdrawal from a fiduciary bank account established under Section
31 4151.107 may be made only as provided in the written agreement for
32 any of the following purposes:

33 (1) delivery to an insurer, plan, or plan sponsor
34 entitled to payment;

35 (2) deposit in an account controlled and maintained in
36 the name of the insurer, plan, or plan sponsor;

37 (3) transfer to and deposit in a claims payment
38 account for payment of a claim as provided by Section 4151.111;

39 (4) payment to a group policyholder for delivery to
40 the insurer entitled to payment;

41 (5) payment to the administrator of the

1 administrator's commission, fees, or charges;

2 (6) delivery of a return premium to any person
3 entitled to payment; or

4 (7) payment of a premium for stop-loss or excess loss
5 insurance. (V.T.I.C. Art. 21.07-6, Sec. 17(e).)

6 Source Law

7 (e) Withdrawals from the fiduciary bank account
8 must be made as provided in the written agreement
9 between the administrator and the insurer, plan, or
10 plan sponsor for any of the following purposes:

11 (1) remittance to an insurer, plan, or
12 plan sponsor entitled to payment;

13 (2) deposit in an account controlled and
14 maintained in the name of the insurer, plan, or plan
15 sponsor;

16 (3) transfer to and deposit in a claims
17 payment account for payment of claims as provided by
18 Section 18 of this article;

19 (4) payment to a group policyholder for
20 remittance to the insurer entitled to payment;

21 (5) payment to the administrator of its
22 commission, fees, or charges;

23 (6) remittance of return premiums to any
24 person entitled to payment; or

25 (7) payment of premiums for stop-loss or
26 excess of loss insurance.

27 Revisor's Note

28 Section 17(e)(7), V.T.I.C. Article 21.07-6,
29 refers to "excess of loss insurance." The revised law
30 substitutes "excess loss insurance" for "excess of
31 loss insurance" because the terms are synonymous and
32 the former is more commonly used.

33 Revised Law

34 Sec. 4151.109. PAYMENT OF CLAIMS FROM FIDUCIARY ACCOUNT
35 PROHIBITED. An administrator may not pay a claim from a fiduciary
36 bank account established under Section 4151.107. (V.T.I.C.
37 Art. 21.07-6, Sec. 17(d).)

38 Source Law

39 (d) An administrator may not pay any claims from
40 the fiduciary bank account.

41 Revised Law

42 Sec. 4151.110. UNDERWRITING STANDARDS. If an administrator
43 has the authority to accept or reject a risk, the written agreement
44 must address underwriting or other standards of the insurer or

1 plan. (V.T.I.C. Art. 21.07-6, Sec. 16.)

2 Source Law

3 Sec. 16. If the administrator has the authority
4 to accept or reject risks, the written agreement
5 required by this article shall address underwriting or
6 other standards of the insurer or plan.

7 Revised Law

8 Sec. 4151.111. ADJUDICATION OF CLAIMS. (a) An
9 administrator shall adjudicate a claim not later than the 60th day
10 after the date on which the administrator receives valid proof of
11 loss in connection with the claim.

12 (b) The administrator shall pay each claim on a draft
13 authorized by the insurer, plan, or plan sponsor in the written
14 agreement. (V.T.I.C. Art. 21.07-6, Sec. 18.)

15 Source Law

16 Sec. 18. The administrator shall adjudicate the
17 claims not later than the 60th day after the date on
18 which valid proof of loss is received by the
19 administrator. The administrator shall pay each claim
20 on a draft authorized by the insurer, plan, or plan
21 sponsor in the written agreement.

22 Revised Law

23 Sec. 4151.112. MAINTENANCE OF BOOKS AND RECORDS. (a) An
24 administrator shall maintain at the administrator's principal
25 administrative office adequate books and records of each
26 transaction in which the administrator engages with an insurer,
27 plan, plan sponsor, insured, or plan participant.

28 (b) The administrator shall maintain the books and records:

29 (1) until the fifth anniversary of the end of the term
30 of the written agreement to which the books and records relate; and

31 (2) in accordance with prudent standards of insurance
32 recordkeeping. (V.T.I.C. Art. 21.07-6, Secs. 14(a), (b), (c).)

33 Source Law

34 Sec. 14. (a) Each administrator shall maintain
35 at its principal administrative office adequate books
36 and records of all transactions in which the
37 administrator engages with insurers, plans, plan
38 sponsors, insureds, and plan participants.

39 (b) The books and records must be maintained for
40 the term of the written agreement to which they relate
41 and for the five-year period following the end of the
42 written agreement's term.

1 (c) The administrator shall maintain the books
2 and records in accordance with prudent standards of
3 insurance recordkeeping.

4 Revised Law

5 Sec. 4151.113. ACCESS TO BOOKS AND RECORDS. (a) For the
6 purpose of examination, audit, and inspection, the administrator
7 shall provide to the commissioner and the commissioner's designee
8 access to the books and records maintained as required by Section
9 4151.112.

10 (b) A trade secret, including the identity and address of a
11 policyholder or certificate holder, is confidential, except the
12 commissioner may use that information in a proceeding against the
13 administrator.

14 (c) An insurer, plan, or plan sponsor is entitled to
15 continuing access to the books and records sufficient to permit the
16 insurer, plan, or plan sponsor to fulfill a contractual obligation
17 to an insured or plan participant. The right provided by this
18 subsection is subject to any restriction included in the written
19 agreement relating to the parties' proprietary rights to the books
20 and records. (V.T.I.C. Art. 21.07-6, Secs. 14(d), (e), (f).)

21 Source Law

22 (d) The commissioner and his designated
23 representative must be given access to those books and
24 records for the purpose of examination, audit, and
25 inspection.

26 (e) Trade secrets, including the identity and
27 addresses of policyholders and certificate holders,
28 are confidential, except the commissioner may use that
29 information in proceedings instituted against the
30 administrator.

31 (f) An insurer, plan, or plan sponsor is
32 entitled to continuing access to these books and
33 records sufficient to permit the insurer, plan, or
34 plan sponsor to fulfill contractual obligations to
35 insureds and plan participants. The right provided by
36 this subsection is subject to any restrictions
37 included in the written agreement between the
38 administrator and the insurer, plan, or plan sponsor
39 relating to proprietary rights of the parties to the
40 books and records.

41 Revised Law

42 Sec. 4151.114. DISPOSITION OF BOOKS AND RECORDS ON
43 TERMINATION OF WRITTEN AGREEMENT. On termination of the written
44 agreement, an administrator may fulfill the requirements of

1 Sections 4151.112 and 4151.113 by:

2 (1) delivering the books and records:

3 (A) to a successor administrator; or

4 (B) if there is not a successor administrator, to
5 the insurer, plan, or plan sponsor; and

6 (2) giving written notice to the commissioner of the
7 location of the books and records. (V.T.I.C. Art. 21.07-6, Sec.
8 14(g).)

9 Source Law

10 (g) An administrator may fulfill the legal
11 requirements of this section on termination of the
12 written agreement by delivering to the successor
13 administrator or, if there is no successor
14 administrator, to the insurer, plan, or plan sponsor
15 the books and records and by giving written notice to
16 the commissioner of the location of the books and
17 records.

18 Revised Law

19 Sec. 4151.115. CONFIDENTIALITY OF PERSONAL INFORMATION.

20 (a) Information that identifies an individual covered by a plan is
21 confidential.

22 (b) During the time information described by Subsection (a)
23 is in an administrator's custody or control, the administrator
24 shall take all reasonable precautions to prevent disclosure or use
25 of the information for a purpose unrelated to administration of the
26 plan.

27 (c) The administrator shall disclose information described
28 by Subsection (a) only:

29 (1) in response to a court order;

30 (2) for an examination conducted by the commissioner
31 under this chapter;

32 (3) for an audit or investigation conducted under the
33 Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et
34 seq.);

35 (4) to or at the request of the insurer or plan
36 sponsor; or

37 (5) with the written consent of the identified

1 individual or the individual's legal representative. (V.T.I.C.
2 Art. 21.07-6, Sec. 14A.)

3 Source Law

4 Sec. 14A. (a) Information that identifies an
5 individual covered by a plan is confidential.

6 (b) During the time information described in
7 Subsection (a) of this section is in an administrator's
8 custody or control, the administrator shall take all
9 reasonable precautions to prevent disclosure or use of
10 the information for a purpose unrelated to
11 administration of the plan.

12 (c) The administrator shall disclose
13 information described in Subsection (a) of this
14 section only:

15 (1) in response to a court order;

16 (2) for an examination conducted by the
17 commissioner under this article;

18 (3) for an audit or investigation
19 conducted under the Employee Retirement Income
20 Security Act of 1974 (29 U.S.C. 1001, et seq.);

21 (4) to or at the request of the insurer or
22 plan sponsor; or

23 (5) with the written consent of the
24 identified individual or his or her legal
25 representative.

26 Revised Law

27 Sec. 4151.116. ADVERTISING. Before an administrator uses
28 advertising relating to business underwritten by an insurer, plan,
29 or plan sponsor, the insurer, plan, or plan sponsor must approve use
30 of the advertising. (V.T.I.C. Art. 21.07-6, Sec. 15.)

31 Source Law

32 Sec. 15. An administrator may use only
33 advertising relating to business underwritten by an
34 insurer, plan, or plan sponsor that is approved by the
35 insurer, plan, or plan sponsor in advance of its use.

36 Revised Law

37 Sec. 4151.117. COMPENSATION OF ADMINISTRATOR. An
38 administrator's compensation may be determined:

39 (1) as a percentage of the premiums or charges the
40 administrator collects or the amount of claims the administrator
41 pays or processes; or

42 (2) on another basis as specified in the written
43 agreement. (V.T.I.C. Art. 21.07-6, Sec. 19.)

44 Source Law

45 Sec. 19. The compensation to the administrator
46 may be based on a percentage of the premiums or charges
47 collected, the amount of claims paid or processed, or

1 on such other basis as specified in the written
2 agreement.

3 [Sections 4151.118-4151.150 reserved for expansion]

4 SUBCHAPTER D. PHARMACY BENEFIT PLANS

5 Revised Law

6 Sec. 4151.151. DEFINITION. In this subchapter, "pharmacy
7 benefit manager" means a person, other than a pharmacy or
8 pharmacist, who acts as an administrator in connection with
9 pharmacy benefits. (V.T.I.C. Art. 21.07-6, Sec. 1(9).)

10 Source Law

11 Sec. 1. In this article:

12 (9) "Pharmacy benefit manager" means a
13 person, other than a pharmacy or pharmacist, who acts
14 as an administrator in connection with pharmacy
15 benefits.

16 Revised Law

17 Sec. 4151.152. IDENTIFICATION CARDS. (a) Except as
18 provided by rules adopted by the commissioner, an administrator for
19 a plan that provides pharmacy benefits shall issue an
20 identification card to each individual covered by the plan. The
21 administrator shall issue the identification card not later than
22 the 30th day after the date the administrator receives notice that
23 the individual is eligible for the benefits.

24 (b) The commissioner by rule shall adopt standard
25 information to be included on the identification card. The
26 standard form identification card must include:

27 (1) the name or logo of the entity administering the
28 pharmacy benefits;

29 (2) the international identification number assigned
30 by the American National Standards Institute for the entity
31 administering the pharmacy benefits;

32 (3) the group number applicable to the covered
33 individual;

34 (4) the effective date of the coverage evidenced by
35 the card;

36 (5) a telephone number to be used to contact an

1 appropriate person to obtain information relating to the pharmacy
2 benefits provided under the coverage; and

3 (6) copayment information for generic and brand-name
4 prescription drugs. (V.T.I.C. Art. 21.07-6, Sec. 19A.)

5 Source Law

6 Sec. 19A. (a) Except as provided by rules
7 adopted by the commissioner, an administrator for a
8 plan that provides pharmacy benefits shall issue an
9 identification card to each individual covered by the
10 plan.

11 (b) The commissioner by rule shall adopt
12 standard information to be included on the
13 identification card. At minimum, the standard form
14 identification card must include:

15 (1) the name or logo of the entity that is
16 administering the pharmacy benefits;

17 (2) the International Identification
18 Number that is assigned by the American National
19 Standards Institute for the entity that is
20 administering the pharmacy benefits;

21 (3) the group number applicable for the
22 individual;

23 (4) the effective date of the coverage
24 evidenced by the card;

25 (5) a telephone number to be used to
26 contact an appropriate person to obtain information
27 relating to the pharmacy benefits provided under the
28 coverage; and

29 (6) copayment information for generic and
30 brand-name prescription drugs.

31 (c) An administrator for a plan that provides
32 pharmacy benefits shall issue to an individual an
33 identification card not later than the 30th day after
34 the date the administrator receives notice that the
35 individual is eligible for the benefits.

36 Revised Law

37 Sec. 4151.153. DISCLOSURE OF CERTAIN PATIENT INFORMATION
38 PROHIBITED. (a) A pharmacy benefit manager may not sell a list of
39 patients that contains information through which the identity of an
40 individual patient is disclosed.

41 (b) A pharmacy benefit manager shall maintain all data that
42 identifies a patient in a confidential manner that prevents
43 disclosure to a third party unless the disclosure is otherwise
44 authorized by law or by the patient.

45 (c) This section does not prohibit:

46 (1) general advertising about a specific
47 pharmaceutical product or service; or

48 (2) the request and receipt by a person of information

1 regarding:

2 (A) a specific pharmaceutical product or
3 service;

4 (B) the person's own records or claims; or

5 (C) the person's dependent's records or claims.

6 (V.T.I.C. Art. 21.07-6, Sec. 19B.)

7 Source Law

8 Sec. 19B. (a) A pharmacy benefit manager may
9 not sell a list of patients that contains information
10 through which the identity of individual patients is
11 disclosed.

12 (b) All data that identifies a patient
13 maintained by the pharmacy benefit manager shall be
14 maintained in a confidential manner that prevents
15 disclosure to third parties, unless the disclosure is
16 otherwise authorized by law or by the patient.

17 (c) This section does not prohibit:

18 (1) general advertising about a specific
19 pharmaceutical product or service;

20 (2) a person from requesting and receiving
21 information regarding a specific pharmaceutical
22 product or service; or

23 (3) a person from requesting and receiving
24 information regarding the person's own records or
25 claims, or information regarding the person's
26 dependent's records or claims.

27 [Sections 4151.154-4151.200 reserved for expansion]

28 SUBCHAPTER E. REGULATION OF THIRD-PARTY ADMINISTRATORS

29 Revised Law

30 Sec. 4151.201. EXAMINATION OF ADMINISTRATOR. (a) The
31 commissioner may examine an administrator with regard to its
32 business in this state.

33 (b) The commissioner may designate one or more employees to
34 perform an examination. (V.T.I.C. Art. 21.07-6, Secs. 8(a), (b).)

35 Source Law

36 Sec. 8. (a) The commissioner may examine each
37 administrator that has a certificate of authority with
38 regard to its business conducted in this state.

39 (b) The commissioner may designate certain
40 employees to perform the examinations.

41 Revisor's Note

42 Section 8(a), V.T.I.C. Article 21.07-6,
43 authorizes the commissioner of insurance to examine
44 each administrator "that has a certificate of
45 authority." The revised law omits the quoted language

1 as unnecessary because under Section 3(a), V.T.I.C.
2 Article 21.07-6, which is revised as Section
3 4151.051(a), a person may not act as an administrator
4 in this state unless the person holds a certificate of
5 authority under this chapter.

6 Revised Law

7 Sec. 4151.202. CONTENTS OF EXAMINATION; ON-SITE
8 EVALUATION. (a) An examination under Section 4151.201 must
9 include a review of:

10 (1) each existing written agreement between the
11 administrator and an insurer or plan sponsor; and

12 (2) the administrator's financial statements.

13 (b) The commissioner also may have examiners conduct an
14 on-site evaluation of the administrator's personnel and facilities
15 and any books and records of the administrator relating to the
16 transaction of business by and the financial condition of the
17 administrator.

18 (c) Before an examiner enters an administrator's property,
19 the commissioner shall give notice to the administrator of the
20 examiner's intent to conduct an on-site evaluation. The notice
21 must:

22 (1) be in the form required by rule adopted by the
23 commissioner; and

24 (2) include the date and estimated time that the
25 examiner will enter the administrator's property.

26 (d) An examiner shall comply with operational rules of an
27 administrator while on the administrator's property. (V.T.I.C.
28 Art. 21.07-6, Secs. 8(c), (d).)

29 Source Law

30 (c) An examination shall include:

31 (1) review of all existing written
32 agreements between the administrator and various
33 insurers and plans; and

34 (2) review of the financial statements of
35 the administrator.

36 (d) The commissioner also may have examiners
37 make an on-site evaluation of the administrator's
38 personnel and facilities and any books and records of

1 the administrator relating to the transaction of
2 business and the financial condition of the
3 administrator. Before an examiner enters the property
4 of an administrator, the commissioner shall give
5 notice to the administrator of the intent to have an
6 on-site evaluation by an examiner. The notice must be
7 in the form required by board rule and shall include
8 the date and estimated time that the examiner will
9 enter the property of the administrator. An examiner
10 shall comply with operational rules of the
11 administrator while on the administrator's property.

12 Revised Law

13 Sec. 4151.203. COST OF EXAMINATION. The cost of an
14 examination under Section 4151.201 shall be paid from the fee
15 collected under Section 4151.206(a)(2) and with revenue from the
16 maintenance tax levied under Chapter 259. (V.T.I.C. Art. 21.07-6,
17 Sec. 8(f).)

18 Source Law

19 (f) The cost of examinations under this section
20 shall be paid from the fee collected under Section 20
21 of this Act and with revenues from the maintenance tax
22 levied under Section 21 of this Act pursuant to
23 legislative appropriation.

24 Revisor's Note

25 Section 8(f), V.T.I.C. Article 21.07-6, provides
26 that the cost of an examination under Section 8,
27 Article 21.07-6, is to be paid out of certain revenue
28 "pursuant to legislative appropriation." The revised
29 law omits the quoted language as unnecessary because
30 under Section 6, Article VIII, Texas Constitution,
31 money may not be drawn from the treasury unless a
32 specific appropriation is made.

33 Revised Law

34 Sec. 4151.204. EXAMINATION UNDER OATH. If necessary to
35 make a complete evaluation of the activities and operations of an
36 administrator, the commissioner may summon and examine under oath
37 the administrator and the administrator's personnel. (V.T.I.C.
38 Art. 21.07-6, Sec. 8(e).)

39 Source Law

40 (e) The commissioner may summon and examine
41 under oath the administrator and the administrator's
42 personnel, if necessary to make a complete evaluation
43 of the activities and operations of an administrator.

1 Revised Law

2 Sec. 4151.205. ANNUAL REPORT. (a) An administrator shall
3 annually, not later than March 1, file with the commissioner a
4 report on a form prescribed by the commissioner.

5 (b) The annual report must cover the preceding calendar
6 year. (V.T.I.C. Art. 21.07-6, Sec. 9.)

7 Source Law

8 Sec. 9. (a) Each administrator operating under
9 a certificate of authority issued under this article
10 shall file with the commissioner an annual report.

11 (b) The annual report shall cover the preceding
12 calendar year and must be filed with the commissioner
13 not later than March 1 of the year following the year
14 covered by the report on a form prescribed by the
15 board.

16 Revisor's Note

17 Section 9(a), V.T.I.C. Article 21.07-6, requires
18 each administrator "operating under a certificate of
19 authority issued under this article" to file an annual
20 report. The revised law omits the quoted language for
21 the reason stated in the revisor's note to Section
22 4151.201.

23 Revised Law

24 Sec. 4151.206. FEES. (a) The commissioner shall collect
25 and an applicant or administrator shall pay to the commissioner
26 fees in an amount to be determined by the commissioner as follows:

27 (1) a filing fee not to exceed \$1,000 for processing an
28 original application for a certificate of authority for an
29 administrator;

30 (2) a fee not to exceed \$500 for an examination under
31 Section 4201.201; and

32 (3) a filing fee not to exceed \$200 for an annual
33 report.

34 (b) The commissioner shall deposit a fee collected under
35 this section to the credit of the Texas Department of Insurance
36 operating account. (V.T.I.C. Art. 21.07-6, Sec. 20.)

1 Source Law

2 Sec. 20. (a) The commissioner shall collect
3 and the persons affected shall pay to the commissioner
4 fees in an amount to be determined by the board not to
5 exceed the following:

6 (1) filing fee for processing an original
7 application for certificate of authority for an
8 administrator, \$1,000;

9 (2) fee for an examination under Section 8
10 of this article, \$500; and

11 (3) filing fee for an annual report, \$200.

12 (b) Fees collected under this section shall be
13 deposited in the state treasury to the credit of the
14 State Board of Insurance operating fund to be used by
15 the board as provided by legislative appropriation.

16 Revisor's Note

17 (1) Section 20(b), V.T.I.C. Article 21.07-6,
18 requires fees to be deposited in the state treasury to
19 the credit of the State Board of Insurance operating
20 fund. Under the authority of Chapter 4, Acts of the
21 72nd Legislature, 1st Called Session, 1991, that fund
22 was converted to an account in the general revenue
23 fund. The revised law is drafted accordingly.

24 (2) Section 20(b), V.T.I.C. Article 21.07-6,
25 provides that fees collected under Section 20 are to be
26 deposited in the State Board of Insurance operating
27 fund to be used by the board "as provided by
28 legislative appropriation." The revised law omits the
29 quoted language for the reason stated in the revisor's
30 note to Section 4151.203.

31 Revised Law

32 Sec. 4151.207. ADMINISTRATIVE SANCTIONS. An administrator
33 or other person who violates this chapter is subject to the
34 sanctions provided by Chapter 82. (V.T.I.C. Art. 21.07-6, Sec.
35 22.)

36 Source Law

37 Sec. 22. A person or administrator who violates
38 this article is subject to the sanctions provided by
39 Section 7, Article 1.10, of this code.

40 Revised Law

41 Sec. 4151.208. OFFENSE. (a) An administrator commits an
42 offense if the administrator knowingly violates this chapter or a

1 rule of the commissioner adopted under this chapter.

2 (b) An offense under this section is a misdemeanor
3 punishable by a fine of not less than \$500 or more than \$5,000.
4 (V.T.I.C. Art. 21.07-6, Sec. 7.)

5 Source Law

6 Sec. 7. (a) An administrator commits an
7 offense if the administrator knowingly violates this
8 article or a rule of the board adopted under this
9 article.

10 (b) An offense under this section is a
11 misdemeanor punishable by a fine of not less than \$500
12 and not to exceed \$5,000.

13 CHAPTER 4152. REINSURANCE INTERMEDIARIES

14 SUBCHAPTER A. GENERAL PROVISIONS

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17		INSURER	1964
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20 [Sections 4152.005-4152.050 reserved for expansion]

21 SUBCHAPTER B. LICENSE REQUIREMENTS

22	Sec. 4152.051.	LICENSE REQUIRED.	1966
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26	Sec. 4152.055.	FEES.	1968
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30	Sec. 4152.059.	LICENSE EXPIRATION AND RENEWAL.	1970

31 [Sections 4152.060-4152.100 reserved for expansion]

32 SUBCHAPTER C. EXAMINATION OF REINSURANCE INTERMEDIARIES

33	Sec. 4152.101.	EXAMINATION BY COMMISSIONER	1971
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2	SUBCHAPTER D. REQUIREMENTS RELATING TO BROKERS	
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8	[Sections 4152.155-4152.200 reserved for expansion]	
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11	Sec. 4152.202. TERMINATION OF CONTRACT	1980
12	Sec. 4152.203. ACCOUNTING FOR TRANSACTIONS	1980
13	Sec. 4152.204. MANAGEMENT OF MONEY	1981
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16	Sec. 4152.207. COMPLIANCE WITH UNDERWRITING AND RATING	
17	STANDARDS OF INSURER	1984
18	Sec. 4152.208. SETTLEMENT OF CLAIMS	1985
19	Sec. 4152.209. PAYMENT OF INTERIM PROFITS	1986
20	Sec. 4152.210. AUDITED STATEMENT OF MANAGER'S FINANCIAL	
21	CONDITION	1987
22	Sec. 4152.211. DISCLOSURE OF RELATIONSHIPS WITH OTHER	
23	INSURERS	1987
24	Sec. 4152.212. ACTS OF MANAGER CONSIDERED ACTS OF INSURER . .	1987
25	Sec. 4152.213. ACTUARY'S OPINION ON ADEQUACY OF LOSS	
26	RESERVES	1988
27	Sec. 4152.214. PLACEMENT OF REINSURANCE WITH UNAUTHORIZED	
28	REINSURER	1988
29	Sec. 4152.215. PROHIBITIONS	1989
30	Sec. 4152.216. EMPLOYMENT OF PERSON BY INSURER AND	
31	MANAGER	1990
32	[Sections 4152.217-4152.250 reserved for expansion]	

1 SUBCHAPTER F. REQUIREMENTS RELATING TO INSURERS

2 Sec. 4152.251. ENGAGEMENT OF SERVICES OF UNLICENSED BROKER
3 OR MANAGER 1991
4 Sec. 4152.252. AUDITED STATEMENT OF MANAGER'S FINANCIAL
5 CONDITION 1991
6 Sec. 4152.253. REVIEW OF UNDERWRITING AND CLAIMS PROCESSING
7 OPERATIONS 1991
8 Sec. 4152.254. AUTHORITY FOR RETROCESSIONAL CONTRACTS OR
9 PARTICIPATION IN REINSURANCE SYNDICATES . . 1992
10 Sec. 4152.255. NOTIFICATION OF TERMINATION OF MANAGER'S
11 CONTRACT 1992
12 Sec. 4152.256. APPOINTMENT OF CERTAIN PERSONS TO BOARD OF
13 DIRECTORS PROHIBITED 1992

14 [Sections 4152.257-4152.300 reserved for expansion]

15 SUBCHAPTER G. DISCIPLINE AND ENFORCEMENT

16 Sec. 4152.301. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY
17 ACTION 1993
18 Sec. 4152.302. IMPOSITION OF SANCTIONS. 1994

19 CHAPTER 4152. REINSURANCE INTERMEDIARIES

20 SUBCHAPTER A. GENERAL PROVISIONS

21 Revised Law

22 Sec. 4152.001. DEFINITIONS. In this chapter:

23 (1) "Actuary" means a member in good standing of the
24 American Academy of Actuaries.

25 (2) "Broker" means a person, other than an officer or
26 employee of an insurer, who solicits, negotiates, or places
27 reinsurance business on behalf of an insurer and who may not
28 exercise the authority to bind reinsurance on behalf of that
29 insurer.

30 (3) "Control" has the meaning described by Sections
31 823.005 and 823.151.

32 (4) "Insurer" means a commercially domiciled insurer
33 or other person legally organized in this state to engage in the
34 business of insurance as an insurance company, including:

- 1 (A) a capital stock insurance company;
- 2 (B) a mutual insurance company;
- 3 (C) a title insurance company;
- 4 (D) a fraternal benefit society;
- 5 (E) a local mutual aid association;
- 6 (F) a statewide mutual assessment company;
- 7 (G) a county mutual insurance company;
- 8 (H) a Lloyd's plan;
- 9 (I) a reciprocal or interinsurance exchange;
- 10 (J) a stipulated premium company;
- 11 (K) a group hospital service corporation;
- 12 (L) a farm mutual insurance company; and
- 13 (M) a risk retention group.

14 (5) "Manager" means a person who has the authority to
15 bind reinsurance or who manages all or part of the reinsurance
16 business of an insurer, including the management of a separate
17 division, department, or underwriting office, and who acts as an
18 agent for that insurer. The term does not include:

- 19 (A) an employee of the insurer;
- 20 (B) a manager of the United States branch of an
21 alien insurer;

22 (C) an underwriting manager who, under a
23 contract, manages all of the reinsurance operations of an insurer,
24 who is under common control with the insurer under Chapter 823, and
25 whose compensation is not based on the volume of premiums written;
26 or

27 (D) a manager of a group, association, pool, or
28 other organization of insurers who engages in joint underwriting or
29 joint reinsurance and who is subject to examination by the
30 insurance commissioner or other appropriate officer of the state in
31 which the manager's principal business office is located.

32 (6) "Person" means an individual or a corporation,
33 partnership, association, or other private legal entity.

34 (7) "Qualified United States financial institution"

1 means an institution that is:

2 (A) organized or, in the case of a United States
3 office of a foreign banking organization, licensed under the laws
4 of the United States or a state; and

5 (B) regulated, supervised, and examined by
6 United States federal or state authorities who have regulatory
7 authority over banks and trust companies.

8 (8) "Reinsurance" means a written contract that for
9 consideration transfers an insurance risk of loss between insurers
10 and indemnifies a ceding insurer against all or part of the loss
11 that the ceding insurer may sustain under an insurance policy the
12 ceding insurer has issued or assumed. The term does not include a
13 contract for the bulk sale, transfer, and assumption of direct
14 insurance policy liability to the insureds.

15 (9) "Reinsurance intermediary" means a broker or
16 manager.

17 (10) "Reinsurer" means an insurer who has the
18 authority to assume reinsurance, including retrocessions. The term
19 includes a retrocessionaire. (V.T.I.C. Art. 21.07-7, Secs. 2(1),
20 (2), (4), (5), (6), (7), (8), (9), (10), (11).)

21 Source Law

22 Sec. 2. In this Act:

23 (1) "Actuary" means a member in good
24 standing of the American Academy of Actuaries.

25 (2) "Broker" means a person, other than an
26 officer or employee of an insurer, who solicits,
27 negotiates, or places reinsurance business on behalf
28 of an insurer and who may not exercise the authority to
29 bind reinsurance on behalf of that insurer.

30 (4) "Control" has the meaning assigned
31 that term by Section 2(c), Article 21.49-1 of this
32 code.

33 (5) "Insurer" means a commercially
34 domiciled insurer or other person legally organized in
35 this state to do business as an insurance company,
36 including:

- 37 (A) a capital stock company;
38 (B) a mutual company;
39 (C) a title insurance company;
40 (D) a fraternal benefit society;
41 (E) a local mutual aid association;
42 (F) a statewide mutual assessment
43 company;
44 (G) a county mutual insurance
45 company;

1 (H) a Lloyd's plan company;
2 (I) a reciprocal or interinsurance
3 exchange;
4 (J) a stipulated premium insurance
5 company;
6 (K) a group hospital service company;
7 (L) a farm mutual insurance company;
8 and
9 (M) a risk retention group.

10 (6) "Manager" means a person who has
11 authority to bind reinsurance or who manages all or
12 part of the reinsurance business of an insurer,
13 including the management of a separate division,
14 department, or underwriting office, and who acts as an
15 agent for that insurer. The term does not include:

16 (A) an employee of the insurer;
17 (B) a manager of the United States
18 branch of an alien insurer;

19 (C) an underwriting manager who,
20 under a contract, manages all of the reinsurance
21 operations of an insurer, who is under common control
22 with the insurer under Article 21.49-1 of this code,
23 and whose compensation is not based on the volume of
24 premiums written; or

25 (D) the manager of a group,
26 association, pool, or other organization of insurers
27 who engages in joint underwriting or joint reinsurance
28 and who is subject to examination by the insurance
29 commissioner or other appropriate officer of the state
30 in which the manager's principal business office is
31 located.

32 (7) "Person" means an individual,
33 corporation, partnership, association, or other
34 private legal entity.

35 (8) "Qualified United States financial
36 institution" means an institution that is:

37 (A) organized or, in the case of a
38 United States office of a foreign banking
39 organization, licensed under the laws of the United
40 States or any state of the United States; and

41 (B) regulated, supervised, and
42 examined by United States federal or state authorities
43 who have regulatory authority over banks and trust
44 companies.

45 (9) "Reinsurance" means a written contract
46 that transfers for consideration an insurance risk of
47 loss between insurers and indemnifies a ceding insurer
48 against all or part of the loss that the latter may
49 sustain under an insurance policy it has issued or
50 assumed, but does not mean a contract for the bulk
51 sale, transfer, and assumption of direct insurance
52 policy liability to the insureds.

53 (10) "Reinsurance intermediary" means a
54 broker or manager.

55 (11) "Reinsurer" means an insurer with
56 authority to assume reinsurance, including
57 retrocessions. The term includes a retrocessionaire.

58 Revisor's Note

59 Section 2(4), V.T.I.C. Article 21.07-7, provides
60 that "control" has the meaning assigned by Section
61 2(c), V.T.I.C. Article 21.49-1. The cross-reference
62 is incorrect. It is clear from the context that the

1 correct cross-reference should be to Section 2(d) of
2 that article. That subsection is codified as Sections
3 823.005 and 823.151 of this code, and the revised law
4 is drafted accordingly.

5 Revised Law

6 Sec. 4152.002. CLASSIFICATION AS COMMERCIALY DOMICILED
7 INSURER. (a) For purposes of this chapter, a foreign or alien
8 insurer authorized to engage in the business of insurance in this
9 state is a commercially domiciled insurer if during the period
10 described by Subsection (b) the average of the gross premiums
11 written by the insurer in this state is:

12 (1) more than the average of the gross premiums
13 written by the insurer in the insurer's state of domicile; and

14 (2) 20 percent or more of the total gross premiums
15 written by the insurer in the United States, as reported in the
16 insurer's three most recent annual statements.

17 (b) The period applicable to Subsection (a) is:

18 (1) the three most recent fiscal years of the insurer
19 that precede the fiscal year in which the determination under this
20 section is made; or

21 (2) if the insurer has been authorized to engage in the
22 business of insurance in this state for less than the period
23 described by Subdivision (1), the period for which the insurer has
24 been authorized to engage in the business of insurance in this
25 state. (V.T.I.C. Art. 21.07-7, Sec. 2(3).)

26 Source Law

27 (3) "Commercially domiciled insurer"
28 means a foreign or alien insurer authorized to do
29 business in this state that during its three preceding
30 fiscal years taken together, or any lesser period of
31 time if it has been licensed to transact business in
32 this state only for that lesser period of time, has
33 written an average of more gross premiums in this state
34 than it has written in its state of domicile during the
35 same period with those gross premiums constituting 20
36 percent or more of its total gross premiums everywhere
37 in the United States for that three-year or lesser
38 period, as reported in its three most recent annual
39 statements.

1 Revised Law

2 Sec. 4152.003. RIGHTS OF THIRD PARTIES NOT AFFECTED. This
3 chapter does not restrict the rights of or confer any additional
4 rights on a policyholder, claimant, creditor, or other third party.
5 (V.T.I.C. Art. 21.07-7, Sec. 10(d).)

6 Source Law

7 (d) This article does not limit or restrict the
8 rights of policyholders, claimants, creditors, or
9 other third parties or confer any additional rights on
10 those persons.

11 Revisor's Note

12 Section 10(d), V.T.I.C. Article 21.07-7,
13 provides that the article does not "limit or restrict"
14 the rights of certain persons. The revised law omits
15 the reference to "limit" because "limit" is included
16 in the meaning of "restrict."

17 Revised Law

18 Sec. 4152.004. RULES. The commissioner may adopt
19 reasonable rules as necessary to implement this chapter. (V.T.I.C.
20 Art. 21.07-7, Sec. 11.)

21 Source Law

22 Sec. 11. The board may adopt reasonable rules as
23 necessary to implement this article.

24 Revisor's Note

25 Section 11, V.T.I.C. Article 21.07-7, refers to
26 the "board," meaning the State Board of Insurance.
27 Chapter 685, Acts of the 73rd Legislature, Regular
28 Session, 1993, abolished the board and transferred its
29 functions to the commissioner of insurance and the
30 Texas Department of Insurance. Throughout this
31 chapter, references to the board have been changed
32 appropriately.

33 Revisor's Note
34 (End of Subchapter)

35 Section 1, V.T.I.C. Article 21.07-7, provides a
36 short title by which the article may be cited. The

1 revised law omits this provision because Article
2 21.07-7 is not a statute of wide application that is
3 frequently referred to by its short title, and the
4 heading to this chapter of the revised law is
5 sufficient to describe the revised law to the reader.
6 The omitted law reads:

7 Art. 21.07-7
8 Sec. 1. This article may be cited as
9 the Reinsurance Intermediary Act.

10 [Sections 4152.005-4152.050 reserved for expansion]

11 SUBCHAPTER B. LICENSE REQUIREMENTS

12 Revised Law

13 Sec. 4152.051. LICENSE REQUIRED. (a) A person may not act
14 as a broker or manager in this state for an insurer engaged in the
15 business of insurance or reinsurance in this state unless the
16 person holds an appropriate license under this chapter.

17 (b) A person who holds a manager license is not required to
18 obtain a broker license but must comply with Subchapter D to act as
19 a broker. (V.T.I.C. Art. 21.07-7, Secs. 3(a), (h); Sec. 7(a).)

20 Source Law

21 Sec. 3. (a) A person may not act as a broker as
22 defined in Section 2(2) of this article in this state
23 for an insurer engaged in the business of insurance or
24 reinsurance in this state unless the person is
25 appropriately licensed in this state. A person may not
26 act as a manager as defined in Section 2(6) of this
27 article for an insurer engaged in the business of
28 insurance or reinsurance in this state unless the
29 person is appropriately licensed in this state.

30 (h) A person who holds a manager license is not
31 required to obtain a broker license but must meet all
32 the requirements of Section 5 of this article to act as
33 a broker.

34 Sec. 7. (a) A person may not act as a manager
35 or broker on behalf of any insurer without holding a
36 license, if required, under this article.

37 Revised Law

38 Sec. 4152.052. QUALIFICATIONS. The commissioner may
39 establish qualifications for a reinsurance intermediary license as
40 reasonably necessary to fulfill the requirements of this chapter.
41 (V.T.I.C. Art. 21.07-7, Sec. 3(f).)

1 (b) A license holder who is a nonresident shall notify the
2 commissioner in writing of each change in the license holder's
3 designated agent under Subsection (a)(2) not later than the 30th
4 day after the date on which the license holder makes the change.
5 The change does not take effect until acknowledged by the
6 commissioner. (V.T.I.C. Art. 21.07-7, Sec. 3(d).)

7 Source Law

8 (d) If the applicant for a reinsurance
9 intermediary license is not a resident of this state,
10 the applicant, as a condition precedent to receiving
11 or holding a license, must designate the commissioner
12 as agent for service of process in the manner, and with
13 the same legal effect, as provided by Article 1.36 of
14 this code, for designation of service of process on
15 unauthorized insurers. The applicant must also
16 furnish the commissioner with the name and address of a
17 resident of this state on whom notices or orders of the
18 commissioner or process affecting the nonresident
19 reinsurance intermediary may be served. A license
20 holder who is a nonresident shall notify the
21 commissioner in writing of each change in the license
22 holder's designated agent for service of process not
23 later than the 30th day after the date on which the
24 license holder makes the change. Such a change does
25 not take effect until acknowledged by the
26 commissioner.

27 Revised Law

28 Sec. 4152.055. FEES. (a) The department shall collect a
29 nonrefundable licensing fee from each reinsurance intermediary who
30 applies for an original or renewal license in this state.

31 (b) The commissioner shall set the fees for original,
32 renewal, and reciprocal licenses in amounts that are reasonable and
33 necessary to cover the costs of the licensing program.

34 (c) The fees shall be deposited to the credit of the Texas
35 Department of Insurance operating account. Money deposited in the
36 account under this subsection may be used by the department only to
37 enforce this chapter. (V.T.I.C. Art. 21.07-7, Secs. 4(a), (b).)

38 Source Law

39 Sec. 4. (a) The board shall collect a
40 nonrefundable licensing fee from each reinsurance
41 intermediary who applies for an original or renewal
42 license in this state. The fees shall be deposited in
43 the state treasury to the credit of the State Board of
44 Insurance operating fund and shall be used to enforce
45 this article.

46 (b) The board shall set the fees for original,
47 renewal, and reciprocal licenses in amounts that are

1 reasonable and necessary to cover the costs of the
2 licensing program.

3 Revisor's Note

4 Section 4(a), V.T.I.C. Article 21.07-7, states
5 that certain fees shall be "deposited in the state
6 treasury to the credit of the State Board of Insurance
7 operating fund." Under Chapter 4, Acts of the 72nd
8 Legislature, 1st Called Session, 1991, the Texas
9 Department of Insurance operating fund (the later name
10 of the State Board of Insurance operating fund) was
11 converted to an account in the general revenue fund.
12 The revised law is drafted accordingly.

13 Revised Law

14 Sec. 4152.056. LICENSE ISSUANCE. The commissioner shall
15 issue a reinsurance intermediary license to a person who complies
16 with this chapter. (V.T.I.C. Art. 21.07-7, Sec. 3(c) (part).)

17 Source Law

18 (c) The commissioner shall issue a reinsurance
19 intermediary license to a person who has complied with
20 the requirements of this article. . . .

21 Revised Law

22 Sec. 4152.057. PERSONS AUTHORIZED TO ACT UNDER LICENSE.

23 (a) A reinsurance intermediary license issued to a firm or
24 association authorizes each member of the firm or association and
25 any designated employee to act as a reinsurance intermediary under
26 the license.

27 (b) A reinsurance intermediary license issued to a
28 corporation authorizes each officer and any designated employee or
29 director of the corporation to act as a reinsurance intermediary
30 under the license. (V.T.I.C. Art. 21.07-7, Sec. 3(c) (part).)

31 Source Law

32 (c) . . . A license issued to a firm or
33 association authorizes all of the members of the firm
34 or association and any designated employees to act as
35 reinsurance intermediaries under the license,
36 and . . . A license issued to a corporation
37 authorizes all of the officers and any designated
38 employees and directors of the corporation to act as
39 reinsurance intermediaries on behalf of the
40 corporation, and . . .

1 Revised Law

2 Sec. 4152.058. BOND OR ERRORS AND OMISSIONS POLICY. (a)
3 The commissioner may require a reinsurance intermediary to:

4 (1) file a bond with the commissioner for the
5 protection of all insurers represented; or

6 (2) maintain an errors and omissions policy.

7 (b) The issuer of the bond or the errors and omissions
8 policy must be acceptable to the commissioner. The bond or the
9 policy must be in an amount determined by the commissioner to be
10 customary and adequate under the circumstances. (V.T.I.C.
11 Art. 21.07-7, Sec. 3(b).)

12 Source Law

13 (b)(1) The commissioner may require a
14 reinsurance intermediary to:

15 (A) file a bond with the commissioner
16 for the protection of all insurers represented; or

17 (B) maintain an errors and omissions
18 policy.

19 (2) The issuer of the bond or the errors
20 and omissions policy must be acceptable to the
21 commissioner and the bond or the policy shall be in an
22 amount determined by the commissioner to be customary
23 and adequate under the circumstances.

24 Revised Law

25 Sec. 4152.059. LICENSE EXPIRATION AND RENEWAL. (a) A
26 reinsurance intermediary license is valid for two years from the
27 date of issuance and may be renewed for two-year terms.

28 (b) The commissioner may adopt standards for the renewal of
29 a reinsurance intermediary license. (V.T.I.C. Art. 21.07-7, Sec.
30 3(i).)

31 Source Law

32 (i) Original reinsurance intermediary licenses
33 are valid for two years from the date of issuance and
34 may be renewed for two-year periods. The commissioner
35 may adopt standards for the renewal of reinsurance
36 intermediary licenses that are consistent with the
37 terms of this article.

38 Revisor's Note

39 Section 3(i), V.T.I.C. Article 21.07-7,
40 authorizes the commissioner of insurance to adopt
41 standards for the renewal of reinsurance intermediary

1 licenses "that are consistent with the terms of this
2 article." The revised law omits the quoted language as
3 unnecessary because under established principles of
4 law regarding agency powers, the commissioner may not
5 adopt standards that are inconsistent with the law
6 that governs the commissioner.

7 [Sections 4152.060-4152.100 reserved for expansion]

8 SUBCHAPTER C. EXAMINATION OF REINSURANCE INTERMEDIARIES

9 Revised Law

10 Sec. 4152.101. EXAMINATION BY COMMISSIONER. (a) A
11 reinsurance intermediary is subject to examination by the
12 commissioner of the reinsurance intermediary's:

13 (1) financial condition; and

14 (2) compliance with the laws of this state affecting
15 the conduct of the reinsurance intermediary's business.

16 (b) A manager may be examined as if the manager were an
17 insurer. (V.T.I.C. Art. 21.07-7, Secs. 9(a) (part), (b), (c)
18 (part).)

19 Source Law

20 Sec. 9. (a) A reinsurance intermediary is
21 subject to examination by the commissioner. . . .

22 (b) A manager may be examined as if the manager
23 were an insurer.

24 (c) A reinsurance intermediary shall submit to
25 an examination of its financial condition and its
26 compliance with the laws of this state affecting the
27 conduct of its business. . . .

28 Revised Law

29 Sec. 4152.102. ACCESS TO AND MAINTENANCE OF BOOKS, BANK
30 ACCOUNTS, AND RECORDS. (a) The commissioner is entitled to access
31 to all books, bank accounts, and records of a reinsurance
32 intermediary.

33 (b) A reinsurance intermediary shall maintain books, bank
34 accounts, and records in a form usable by the commissioner.
35 (V.T.I.C. Art. 21.07-7, Sec. 9(a) (part).)

36 Source Law

37 (a) . . . The commissioner is entitled to
38 access to all books, bank accounts, and records of the

1 reinsurance intermediary, which must be maintained in
2 a form usable to the commissioner.

3 Revised Law

4 Sec. 4152.103. CONDUCT OF EXAMINATION. The commissioner,
5 one or more commissioned examiners, a certified public accountant,
6 or another person qualified to perform the examination shall
7 conduct an examination under this subchapter as the commissioner
8 considers necessary. (V.T.I.C. Art. 21.07-7, Sec. 9(c) (part).)

9 Source Law

10 (c) . . . The commissioner, one or more
11 commissioned examiners, a certified public
12 accountant, or other person qualified to perform the
13 examination shall conduct the examination as the
14 commissioner considers necessary. . . .

15 Revised Law

16 Sec. 4152.104. EXAMINATION EXPENSE. (a) A reinsurance
17 intermediary who is examined under this subchapter shall pay an
18 amount for the expense of the examination that the commissioner
19 certifies as just and reasonable.

20 (b) Expenses relating to an examination conducted under
21 this subchapter may be charged to the person examined in accordance
22 with Article 1.16. (V.T.I.C. Art. 21.07-7, Secs. 4(c), 9(c)
23 (part).)

24 Source Law

25 [Sec. 4]
26 (c) Expenses related to an examination
27 conducted under Section 9 of this article may be
28 charged to the person examined in accordance with
29 Article 1.16 of this code.

30 [Sec. 9]
31 (c) . . . The expense of the examination shall
32 be paid by the examined reinsurance intermediary and
33 shall be set in an amount the commissioner certifies as
34 just and reasonable.

35 [Sections 4152.105-4152.150 reserved for expansion]

36 SUBCHAPTER D. REQUIREMENTS RELATING TO BROKERS

37 Revised Law

38 Sec. 4152.151. CONTRACT BETWEEN BROKER AND INSURER. (a) A
39 broker and an insurer represented by the broker may enter into a
40 transaction only under a written contract that:

41 (1) is executed by a responsible officer of both the

1 broker and the insurer; and

2 (2) specifies the responsibilities of each party.

3 (b) At a minimum, a contract entered into under this section
4 must:

5 (1) authorize the insurer to terminate the broker's
6 authority in writing at any time;

7 (2) require the broker to:

8 (A) provide accounts to the insurer at least
9 quarterly that accurately detail all material transactions,
10 including information necessary to support all commissions,
11 charges, and other fees received by or owing to the broker;

12 (B) pay all money due the insurer not later than
13 the 30th day after the date of receipt;

14 (C) hold all money collected for the insurer's
15 account in a fiduciary capacity in a bank that is a qualified United
16 States financial institution; and

17 (D) if premiums or contributions are collected on
18 behalf of or for more than one insurer:

19 (i) maintain records to identify the
20 ownership interest of each insurer in money held in a fiduciary
21 capacity; and

22 (ii) provide to each insurer on request a
23 copy of the records relating to deposits and withdrawals on behalf
24 of or for that insurer;

25 (3) state that the broker will:

26 (A) comply with:

27 (i) Section 4152.153; and

28 (ii) the written standards established by
29 the insurer for the cession or retrocession of risks ceded;

30 (B) disclose to the insurer any relationship with
31 a reinsurer to which business will be ceded or retroceded; and

32 (C) provide annually to each insurer with whom
33 the broker transacts business an audited statement of the broker's
34 financial condition prepared by a certified public accountant;

- 1 (4) identify:
- 2 (A) the name and address of the insurer;
- 3 (B) the kinds of insurance to be reinsured or
- 4 retroceded;
- 5 (C) the type of reinsurance or retrocessions; and
- 6 (D) the limits of coverage; and
- 7 (5) state the effective date and expiration date of
- 8 the contract. (V.T.I.C. Art. 21.07-7, Sec. 5(a) (part).)

9 Source Law

10 Sec. 5. (a) A transaction between a broker and
11 an insurer represented by the broker may be entered
12 into only under a written contract, executed by a
13 responsible officer of both the insurer and the
14 broker, that specifies the responsibilities of each
15 party. At a minimum, the contract must contain the
16 following provisions:

17 (1) the insurer may terminate the broker's
18 authority in writing at any time;

19 (2) the broker shall render periodic
20 accounts to the insurer at least quarterly that
21 accurately detail all material transactions,
22 including information necessary to support all
23 commissions, charges, and other fees received by or
24 owing to the broker, and shall remit all funds due to
25 the insurer not later than the 30th day after the date
26 of receipt;

27 (3) the broker must hold all funds
28 collected in a fiduciary capacity for the insurer's
29 account in a bank that is a qualified United States
30 financial institution;

31 (4) if premiums or contributions are
32 collected on behalf of or for more than one insurer,
33 the broker shall:

34 (A) maintain records to identify the
35 ownership interest of each insurer of such funds held
36 in a fiduciary capacity; and

37 (B) furnish to the insurer on request
38 copies of the records relating to deposits and
39 withdrawals on behalf of or for that insurer;

40 . . .
41 (6) a statement that the broker will
42 comply with Subsections (c) and (d) of this section;

43 (7) a statement that the broker will
44 comply with the written standards established by the
45 insurer for the cession or retrocession of risks
46 ceded;

47 (8) a statement that the broker will
48 disclose to the insurer any relationship with a
49 reinsurer to which business will be ceded or
50 retroceded;

51 (9) a statement that the broker will
52 provide annually an audited statement of the broker's
53 financial condition, prepared by a certified public
54 accountant, to each insurer with whom the broker
55 transacts business; and

56 (10) identification of the following:

57 (A) the name and address of the
58 insurer;

1 (B) the kinds of insurance to be
2 reinsured or retroceded;
3 (C) the type of reinsurance or
4 retrocessions;
5 (D) the limits of coverage; and
6 (E) the effective date and expiration
7 date of the contract.

8 Revisor's Note

9 (1) Section 5(a)(2), V.T.I.C. Article 21.07-7,
10 requires a broker to render "periodic" accounts to an
11 insurer "at least quarterly." The revised law omits
12 "periodic" as unnecessary because that term is
13 included within the meaning of "at least quarterly."

14 (2) Section 5(a)(5), V.T.I.C. Article 21.07-7,
15 provides that the requirements of Section 5(a)(4) are
16 in addition to the requirements under any other
17 federal or state law. An accepted general principle of
18 statutory construction requires a statute to be given
19 cumulative effect with other statutes unless the
20 statute provides otherwise or unless the statutes are
21 in conflict. The general principle applies to this
22 revision. Accordingly, the revised law omits as
23 unnecessary Section 5(a)(5), V.T.I.C. Article
24 21.07-7. The omitted law reads:

25 (5) the requirements of
26 Subdivision (4) of this subsection are in
27 addition to requirements under any other
28 federal or state law;

29 Revised Law

30 Sec. 4152.152. PLACEMENT OF REINSURANCE WITH UNAUTHORIZED
31 REINSURER. Unless the ceding insurer releases the broker in
32 writing from the broker's obligations under this section, a broker
33 who places reinsurance on behalf of an authorized ceding insurer
34 with a reinsurer that is not authorized, accredited, or trustee in
35 this state under Article 3.10 or 5.75-1 shall:

36 (1) exercise due diligence in inquiring into the
37 financial condition of the reinsurer;

38 (2) disclose to the ceding insurer the broker's
39 findings in connection with the inquiry under Subdivision (1); and

1 (3) make available to the ceding insurer a copy of the
2 current financial statement of the reinsurer. (V.T.I.C.
3 Art. 21.07-7, Sec. 5(b).)

4 Source Law

5 (b) In addition to the requirements imposed
6 under Subsection (a) of this section, if a broker
7 places reinsurance on behalf of a licensed ceding
8 insurer with a reinsurer that is not licensed,
9 accredited, or trustee in this state under Article
10 3.10 or Article 5.75-1 of this code, unless the ceding
11 insurer releases the broker in writing from the
12 broker's obligations under this subsection, the broker
13 shall exercise due diligence in inquiring into the
14 financial condition of the assuming unauthorized
15 reinsurer and, in connection with that inquiry,
16 disclose the findings to the ceding insurer and make
17 available to the ceding insurer a copy of the current
18 financial statement of the reinsurer.

19 Revisor's Note

20 (1) Section 5(b), V.T.I.C. Article 21.07-7,
21 imposes certain duties on brokers "[i]n addition to
22 the requirements imposed under Subsection (a) of this
23 section." The revised law omits the quoted language
24 for the reason stated in Revisor's Note (2) to Section
25 4152.151.

26 (2) Section 5(b), V.T.I.C. Article 21.07-7,
27 refers to a "licensed ceding insurer" and a "reinsurer
28 that is not licensed" meaning, respectively, a ceding
29 insurer that holds a certificate of authority and is
30 thus authorized to engage in business in this state and
31 a reinsurer that does not hold a certificate of
32 authority and is thus not authorized to engage in
33 business in this state. For consistency with the
34 terminology used in this code, the revised law
35 substitutes "authorized" and "not authorized" for
36 "licensed" and "not licensed," respectively,
37 throughout this chapter.

38 Revised Law

39 Sec. 4152.153. TRANSACTION RECORDS. (a) For at least 10
40 years after the expiration of each contract of reinsurance

1 transacted by a broker, the broker shall maintain a complete record
2 for each transaction that contains:

3 (1) the type of contract, limits, underwriting
4 restrictions, classes of risks, and territory;

5 (2) the period of coverage, including effective and
6 expiration dates, cancellation provisions, and notice requirements
7 regarding cancellation;

8 (3) reporting and settlement requirements regarding
9 balances;

10 (4) the rate used to compute the reinsurance premium;

11 (5) the name and address of each ceding or assuming
12 insurer;

13 (6) the rates of all reinsurance commissions,
14 including the commissions on any retrocessions handled by the
15 broker;

16 (7) related correspondence and memoranda;

17 (8) proof of placement;

18 (9) details regarding retrocessions handled by the
19 broker, including the identity and address of each retrocessionaire
20 and the respective percentage of each contract assumed or ceded;

21 (10) financial records, including premium and loss
22 accounts; and

23 (11) if the broker procures a reinsurance contract on
24 behalf of an authorized ceding insurer:

25 (A) written evidence that the assuming insurer
26 has agreed to assume the risk if the contract is procured directly
27 from an assuming insurer; or

28 (B) written evidence that the reinsurer has
29 delegated binding authority to the representative who has agreed to
30 assume the risk and that the representative is qualified to act as a
31 manager under this chapter if the contract is procured through a
32 representative of the assuming insurer, other than an employee.

33 (b) Each insurer subject to a contract of reinsurance
34 transacted by a broker is entitled to access to the information

1 maintained by the broker under Subsection (a) and may copy and audit
2 all accounts and records maintained by the broker related to the
3 insurer's business. The broker shall maintain the information in a
4 form usable by the insurer. (V.T.I.C. Art. 21.07-7, Secs. 5(c),
5 (d).)

6 Source Law

7 (c) For at least 10 years after the expiration
8 of each contract of reinsurance transacted by a
9 broker, the broker shall maintain a complete record
10 for each transaction that states:

11 (1) the type of contract, limits,
12 underwriting restrictions, classes or risks, and
13 territory;

14 (2) the period of coverage, including
15 effective and expiration dates, cancellation
16 provisions, and notice requirements regarding
17 cancellation;

18 (3) reporting and settlement requirements
19 of balances;

20 (4) the rate used to compute the
21 reinsurance premium;

22 (5) the names and addresses of ceding and
23 assuming insurers;

24 (6) the rates of all reinsurance
25 commissions, including the commissions on any
26 retrocessions handled by the broker;

27 (7) related correspondence and memoranda;

28 (8) proof of placement;

29 (9) details regarding retrocessions
30 handled by the broker, including the identity and
31 addresses of retrocessionaires and the respective
32 percentages of each contract assumed or ceded;

33 (10) financial records, including premium
34 and loss accounts; and

35 (11) if the broker procures a reinsurance
36 contract on behalf of a licensed ceding insurer:

37 (A) written evidence that the
38 assuming insurer has agreed to assume the risk if
39 procured directly from an assuming insurer; or

40 (B) if placed through a
41 representative of the assuming insurer, other than an
42 employee, written evidence that the reinsurer has
43 delegated binding authority to the representative who
44 has agreed to assume the risk and that the
45 representative is qualified to act as a manager under
46 this article.

47 (d) Each insurer subject to a contract of
48 reinsurance transacted by a broker is entitled to
49 access to the information maintained by the broker
50 under Subsection (c) of this section and may copy and
51 audit all accounts and records maintained by the
52 broker related to the insurer's business. The broker
53 shall maintain the information in a form usable by the
54 insurer.

55 Revisor's Note

56 Section 5(c)(1), V.T.I.C. Article 21.07-7,
57 refers to "classes or risks" involved in a reinsurance

1 transaction. The revised law substitutes a reference
2 to "classes of risks" for the quoted language because
3 it is clear from the context that the reference to
4 "classes or risks" is a typographical error, and a
5 reference to "classes of risks" is consistent with the
6 language used in other insurance statutes of this
7 state.

8 Revised Law

9 Sec. 4152.154. EMPLOYMENT OF PERSON BY INSURER AND
10 BROKER. A person may not be employed by an insurer and a broker
11 with whom the insurer transacts business unless the broker is:

- 12 (1) under common control with the insurer; and
- 13 (2) subject to Chapter 823. (V.T.I.C. Art. 21.07-7,
14 Sec. 5(e).)

15 Source Law

16 (e) A person may not be employed by an insurer
17 and a broker with whom the insurer transacts business
18 unless the broker is under common control with the
19 insurer and is subject to Article 21.49-1 of this code.

20 [Sections 4152.155-4152.200 reserved for expansion]

21 SUBCHAPTER E. REQUIREMENTS RELATING TO MANAGERS

22 Revised Law

23 Sec. 4152.201. CONTRACT BETWEEN MANAGER AND INSURER. (a) A
24 manager and an insurer represented by the manager may enter into a
25 transaction only under a written contract that:

- 26 (1) is executed by a responsible officer of both the
27 manager and the insurer;
- 28 (2) is approved by the insurer's board of directors or
29 attorney in fact;
- 30 (3) specifies the responsibilities of each party;
- 31 (4) identifies the rate, terms, and purpose of each
32 commission, charge, or other fee the manager may assess the
33 insurer; and
- 34 (5) at a minimum, incorporates the requirements of
35 Sections 4152.202-4152.214.

1 (b) Not later than the 30th day before the date the insurer
2 assumes or cedes business through the manager, a copy of the
3 executed contract must be filed with the commissioner for approval.
4 (V.T.I.C. Art. 21.07-7, Secs. 6(a), (j).)

5 Source Law

6 Sec. 6. (a) A transaction between a manager
7 and an insurer represented by the manager may be
8 entered into only under a written contract, executed
9 by a responsible officer of both the insurer and the
10 manager, that specifies the responsibilities of each
11 party. The contract must be approved by the insurer's
12 board of directors or attorney in fact. Not later than
13 the 30th day before the insurer assumes or cedes
14 business through the manager, a copy of the executed
15 contract must be filed with the commissioner for
16 approval. At a minimum, the contract must incorporate
17 the requirements of this section.

18 (j) The contract must identify the rates, terms,
19 and purposes of commissions, charges, and other fees
20 that the manager may assess the insurer.

21 Revised Law

22 Sec. 4152.202. TERMINATION OF CONTRACT. An insurer may:

23 (1) terminate a contract entered into under Section
24 4152.201 for cause on written notice to the manager by certified
25 mail, return receipt requested; and

26 (2) suspend the authority of the manager to assume or
27 cede business during any dispute regarding the cause for
28 termination. (V.T.I.C. Art. 21.07-7, Sec. 6(b).)

29 Source Law

30 (b) The insurer may terminate the contract for
31 cause on written notice to the manager by certified
32 mail, return receipt requested, and may suspend the
33 authority of the manager to assume or cede business
34 during the pendency of any dispute regarding the cause
35 for termination.

36 Revised Law

37 Sec. 4152.203. ACCOUNTING FOR TRANSACTIONS. A manager who
38 enters into a contract with an insurer under Section 4152.201 shall
39 provide accounts to the insurer at least quarterly that accurately
40 detail all material transactions, including information necessary
41 to support all commissions, charges, and other fees received by or
42 owing to the manager. (V.T.I.C. Art. 21.07-7, Sec. 6(c) (part).)

1 (e) In addition to requirements under any other
2 state or federal law, if premiums or contributions are
3 collected on behalf of or for more than one insurer,
4 the manager shall:

5 (1) keep a separate account for each
6 insurer;

7 (2) obtain and maintain copies of the
8 records for each account; and

9 (3) furnish to the insurer, on request,
10 copies of the records relating to deposits and
11 withdrawals on behalf of or for that insurer.

12 Revisor's Note

13 (1) Section 6(e), V.T.I.C. Article 21.07-7,
14 imposes certain duties on managers "[i]n addition to
15 requirements under any other state or federal law."
16 The revised law omits the quoted language as
17 unnecessary for the reason stated in Revisor's Note (2)
18 to Section 4152.151.

19 (2) Section 6(e)(2), V.T.I.C. Article 21.07-7,
20 requires a manager to "obtain and maintain" copies of
21 certain records. The revised law omits the reference
22 to "obtain" because, in context, "obtain" is included
23 in the meaning of "maintain."

24 Revised Law

25 Sec. 4152.205. TRANSACTION RECORDS. (a) For at least 10
26 years after the expiration of each reinsurance contract transacted
27 by a manager, the manager shall maintain a complete record for each
28 transaction that contains:

29 (1) the type of contract, limits, underwriting
30 restrictions, classes of risks, and territory;

31 (2) the period of coverage, including effective and
32 expiration dates, cancellation provisions and notice requirements
33 regarding cancellation, and disposition of outstanding reserves on
34 covered risks;

35 (3) reporting and settlement requirements regarding
36 balances;

37 (4) the rate used to compute the reinsurance premium;

38 (5) the name and address of each ceding or assuming
39 insurer;

1 (6) the rates of all reinsurance commissions,
2 including the commissions on any retrocessions handled by the
3 manager;

4 (7) related correspondence and memoranda;

5 (8) proof of placement;

6 (9) details regarding retrocessions handled by the
7 manager, as permitted by Section 4152.254, including the identity
8 and address of each retrocessionaire and the respective percentage
9 of each contract assumed;

10 (10) financial records, including premium and loss
11 accounts; and

12 (11) if the manager procures a reinsurance contract on
13 behalf of a ceding insurer:

14 (A) written evidence that the assuming insurer
15 has agreed to assume the risk if the contract is procured directly
16 from an assuming insurer; or

17 (B) written evidence that the reinsurer has
18 delegated binding authority to the representative who has agreed to
19 assume the risk and that the representative is qualified to act as a
20 manager under this chapter if the contract is procured through a
21 representative of the assuming insurer, other than an employee.

22 (b) Each insurer is entitled to access to the information
23 maintained by the manager and may copy all accounts and records
24 maintained by the manager related to the insurer's business. The
25 manager shall maintain the information in a form usable by the
26 insurer. (V.T.I.C. Art. 21.07-7, Secs. 6(f), (g).)

27 Source Law

28 (f) For at least 10 years after the expiration
29 of each contract of reinsurance transacted by the
30 manager, the manager shall maintain a complete record
31 for each transaction that states:

32 (1) the type of contract, limits,
33 underwriting restrictions, classes or risks, and
34 territory;

35 (2) the period of coverage, including
36 effective and expiration dates, cancellation
37 provisions and notice requirements regarding
38 cancellation, and disposition of outstanding reserves
39 on covered risks;

40 (3) reporting and settlement requirements

1 of balances;
2 (4) the rate used to compute the
3 reinsurance premium;
4 (5) the names and addresses of ceding and
5 assuming insurers;
6 (6) the rates of all reinsurance
7 commissions, including the commissions on any
8 retrocessions handled by the manager;
9 (7) related correspondence and memoranda;
10 (8) proof of placement;
11 (9) details regarding retrocessions
12 handled by the manager, as permitted by Section 8(c) of
13 this article, including the identity and addresses of
14 retrocessionaires and the respective percentages of
15 each contract assumed;
16 (10) financial records, including premium
17 and loss accounts; and
18 (11) if the manager places a reinsurance
19 contract on behalf of a ceding insurer:
20 (A) written evidence that the
21 assuming insurer has agreed to assume the risk if
22 procured directly from an assuming insurer; or
23 (B) if placed through a
24 representative of the assuming insurer, other than an
25 employee, written evidence that the reinsurer has
26 delegated binding authority to the representative who
27 has agreed to assume the risk and that the
28 representative is qualified to act as a manager under
29 this article.
30 (g) The insurer is entitled to access to the
31 information maintained by the manager in a form usable
32 by the insurer and may copy all accounts and records
33 maintained by the manager related to the insurer's
34 business.

35 Revisor's Note

36 Section 6(f)(1), V.T.I.C. Article 21.07-7,
37 refers to "classes or risks" involved in a reinsurance
38 transaction. The revised law substitutes a reference
39 to "classes of risks" for the reason stated in the
40 revisor's note to Section 4152.153.

41 Revised Law

42 Sec. 4152.206. CONTRACT ASSIGNMENT PROHIBITED. A manager
43 may not assign in whole or in part a contract entered into under
44 Section 4152.201. (V.T.I.C. Art. 21.07-7, Sec. 6(h).)

45 Source Law

46 (h) The contract may not be assigned in whole or
47 in part by the manager.

48 Revised Law

49 Sec. 4152.207. COMPLIANCE WITH UNDERWRITING AND RATING
50 STANDARDS OF INSURER. A manager shall comply with the written
51 underwriting and rating standards established by an insurer with

1 whom the manager has entered into a contract under Section 4152.201
2 for the acceptance, rejection, or cession of all risks. (V.T.I.C.
3 Art. 21.07-7, Sec. 6(i).)

4 Source Law

5 (i) The manager shall comply with the written
6 underwriting and rating standards established by the
7 insurer for the acceptance, rejection, or cession of
8 all risks.

9 Revised Law

10 Sec. 4152.208. SETTLEMENT OF CLAIMS. (a) This section
11 applies only to a contract entered into under Section 4152.201 that
12 permits a manager to settle claims on behalf of an insurer.

13 (b) All claims must be reported to the insurer at least
14 quarterly.

15 (c) The manager shall send a copy of the claim file to the
16 insurer at the insurer's request or as soon as it is known that the
17 claim:

18 (1) has the potential to exceed the lesser of:

19 (A) an amount determined by the commissioner; or

20 (B) the limit set by the insurer;

21 (2) involves a coverage dispute;

22 (3) may exceed the manager's claims settlement
23 authority;

24 (4) has been open for more than six months; or

25 (5) has been closed by payment of the lesser of:

26 (A) an amount determined by the commissioner; or

27 (B) the limit set by the insurer.

28 (d) A claim file is the joint property of the insurer and
29 manager, except that on an order of liquidation of the insurer the
30 file becomes the sole property of the insurer or the insurer's
31 estate. The manager is entitled to reasonable access to the claim
32 file and may copy the file on a timely basis.

33 (e) Any settlement authority granted to the manager may be
34 terminated for cause on the insurer's written notice by certified
35 mail, return receipt requested, to the manager or on the

1 termination of the contract. The insurer may suspend the
2 settlement authority during any dispute regarding the cause of
3 termination. (V.T.I.C. Art. 21.07-7, Sec. 6(k).)

4 Source Law

5 (k) If the contract permits the manager to
6 settle claims on behalf of the insurer:

7 (1) all claims must be reported to the
8 insurer quarterly or more often;

9 (2) the manager shall send a copy of the
10 claim file to the insurer at the insurer's request or
11 as soon as it is known that the claim:

12 (A) has the potential to exceed the
13 lesser of an amount determined by the commissioner or
14 the limit set by the insurer;

15 (B) involves a coverage dispute;

16 (C) may exceed the manager's claims
17 settlement authority;

18 (D) is open for more than six months;

19 or

20 (E) is closed by payment of the
21 lesser of an amount set by the commissioner or an
22 amount set by the insurer;

23 (3) all claim files are the joint property
24 of the insurer and manager; however, on an order of
25 liquidation of the insurer those files become the sole
26 property of the insurer or the insurer's estate; the
27 manager is entitled to reasonable access to the claim
28 files and may copy the files on a timely basis; and

29 (4) any settlement authority granted to
30 the manager may be terminated for cause on the
31 insurer's written notice by certified mail, return
32 receipt requested, to the manager or on the
33 termination of the contract; the insurer may suspend
34 the settlement authority during the pendency of the
35 dispute regarding the cause of termination.

36 Revised Law

37 Sec. 4152.209. PAYMENT OF INTERIM PROFITS. If a contract
38 entered into under Section 4152.201 provides for the sharing of
39 interim profits by the manager, interim profits may not be paid
40 until:

41 (1) the first anniversary of the end of each
42 underwriting period for property business, the fifth anniversary of
43 the end of each underwriting period for casualty business, or the
44 expiration of the period set by the executive director for those or
45 other specified kinds of insurance; and

46 (2) the adequacy of reserves on remaining claims has
47 been verified under Section 4152.213. (V.T.I.C. Art. 21.07-7, Sec.
48 6(1).)

1 The acts of a manager are considered to be the acts of the insurer on
2 whose behalf the manager is acting. (V.T.I.C. Art. 21.07-7, Sec.
3 6(p).)

4 Source Law

5 (p) The acts of the manager shall be considered
6 the acts of the insurer on whose behalf the manager is
7 acting.

8 Revised Law

9 Sec. 4152.213. ACTUARY'S OPINION ON ADEQUACY OF LOSS
10 RESERVES. In addition to any other required loss reserve
11 certification, a manager who establishes loss reserves shall
12 provide annually, or more frequently as required by other law, an
13 opinion from an actuary attesting to the adequacy of the loss
14 reserves established for losses incurred and outstanding on
15 business produced by the manager. (V.T.I.C. Art. 21.07-7, Sec.
16 6(q).)

17 Source Law

18 (q) If a manager establishes loss reserves, the
19 manager shall provide annually, or more frequently as
20 required by law, an opinion from an actuary attesting
21 to the adequacy of the loss reserves established for
22 losses incurred and outstanding on business produced
23 by the manager. The actuary's opinion is in addition
24 to any other required loss reserve certification.

25 Revised Law

26 Sec. 4152.214. PLACEMENT OF REINSURANCE WITH UNAUTHORIZED
27 REINSURER. (a) Unless the ceding insurer releases the manager in
28 writing from the manager's obligations under this section, a
29 manager who places reinsurance on behalf of an authorized ceding
30 insurer with a reinsurer that is not authorized, accredited, or
31 trustee in this state under Article 3.10 or 5.75-1 shall:

32 (1) exercise due diligence in inquiring into the
33 financial condition of the reinsurer;

34 (2) disclose to the ceding insurer the manager's
35 findings in connection with the inquiry under Subdivision (1); and

36 (3) make available to the ceding insurer a copy of the
37 current financial statement of the reinsurer.

38 (b) A ceding insurer that releases a manager from the

1 manager's obligations under Subsection (a) assumes those
2 obligations. (V.T.I.C. Art. 21.07-7, Sec. 6(r).)

3 Source Law

4 (r) If a manager places reinsurance on behalf of
5 a licensed ceding insurer with a reinsurer that is not
6 licensed, accredited, or trustee in this state under
7 Article 3.10 or Article 5.75-1 of this code, the
8 manager shall exercise due diligence in inquiring into
9 the financial condition of the assuming unauthorized
10 reinsurer and, in connection with that inquiry,
11 disclose the findings to the ceding insurer and make
12 available to the ceding insurer a copy of the current
13 financial statement of the reinsurer. However, the
14 ceding insurer may assume the obligation under this
15 subsection by releasing the intermediary in writing
16 from the obligations imposed under this subsection.

17 Revised Law

18 Sec. 4152.215. PROHIBITIONS. (a) A reinsurance
19 intermediary acting as a manager may not:

20 (1) bind retrocessions on behalf of an insurer, except
21 that the manager may bind facultative retrocessions under
22 obligatory retrocessional agreements if the contract entered into
23 with the insurer under Section 4152.201 contains reinsurance
24 underwriting guidelines for those retrocessions that include:

25 (A) a list of reinsurers with whom those
26 automatic agreements are in effect; and

27 (B) for each reinsurer:

28 (i) the coverages and amounts or
29 percentages that may be reinsured; and

30 (ii) commission schedules;

31 (2) commit an insurer to participate in a reinsurance
32 syndicate;

33 (3) appoint or contract with a broker without ensuring
34 that the broker is qualified to act as a manager under this chapter;

35 (4) without prior approval of the insurer, pay or
36 commit an insurer to pay a claim that exceeds the lesser of:

37 (A) an amount specified by the insurer; or

38 (B) one percent of the insurer's policyholders'
39 surplus as of December 31 of the last complete calendar year; or

40 (5) collect a payment from a retrocessionaire or

1 commit an insurer to a claim settlement with a retrocessionaire
2 without prior approval of the insurer.

3 (b) If prior approval is given as provided by Subsection
4 (a)(5), a report must be forwarded to the reinsurer as provided by
5 Section 4152.203. (V.T.I.C. Art. 21.07-7, Sec. 7(b).)

6 Source Law

7 (b) A reinsurance intermediary acting as a
8 manager may not:

9 (1) bind retrocessions on behalf of the
10 insurer, except that the manager may bind facultative
11 retrocessions under obligatory retrocessional
12 agreements if the contract with the insurer contains
13 reinsurance underwriting guidelines for those
14 retrocessions that include a list of reinsurers with
15 whom those automatic agreements are in effect and, for
16 each reinsurer, the coverages and amounts or
17 percentages that may be reinsured and commission
18 schedules;

19 (2) commit the insurer to participate in
20 reinsurance syndicates;

21 (3) appoint or contract with any broker
22 without assuring that the broker is qualified to act as
23 a manager under this article;

24 (4) without prior approval of the insurer,
25 pay or commit the insurer to pay a claim that exceeds
26 the lesser of an amount specified by the insurer or one
27 percent of the insurer's policyholders' surplus as of
28 December 31 of the last complete calendar year; or

29 (5) collect any payment from a
30 retrocessionaire or commit the insurer to any claim
31 settlement with a retrocessionaire without prior
32 approval of the insurer and, if prior approval is
33 given, a report must be forwarded to the reinsurer
34 under the requirements of Section 6(c) of this
35 article.

36 Revised Law

37 Sec. 4152.216. EMPLOYMENT OF PERSON BY INSURER AND
38 MANAGER. A person may not be employed by an insurer and a manager
39 with whom the insurer transacts business unless the manager is:

40 (1) under common control with the insurer; and

41 (2) subject to Chapter 823. (V.T.I.C. Art. 21.07-7,
42 Sec. 7(c).)

43 Source Law

44 (c) A person may not be employed by an insurer
45 and a manager with whom the insurer transacts business
46 unless the manager is under common control with the
47 insurer and is subject to Article 21.49-1 of this code.

48 [Sections 4152.217-4152.250 reserved for expansion]

1 SUBCHAPTER F. REQUIREMENTS RELATING TO INSURERS

2 Revised Law

3 Sec. 4152.251. ENGAGEMENT OF SERVICES OF UNLICENSED BROKER
4 OR MANAGER. (a) Except as provided by Subsection (b), an insurer
5 may not engage the services of a person to act as a broker or manager
6 on the insurer's behalf unless the person holds a license if
7 required by Section 4152.051.

8 (b) An insurer, or an employee, attorney, or actuary of an
9 insurer, may negotiate and obtain reinsurance for that insurer
10 without holding a broker or manager license or without using the
11 services of a broker or manager if that insurer, employee,
12 attorney, or actuary does not otherwise hold the person out as a
13 broker or manager or perform the duties or provide the services of a
14 broker or manager. (V.T.I.C. Art. 21.07-7, Sec. 8(a).)

15 Source Law

16 Sec. 8. (a) Except as otherwise provided by
17 this subsection, an insurer may not engage the
18 services of any person to act as a broker or manager on
19 the insurer's behalf unless the person is licensed if
20 required by Section 3(a) of this article. An insurer,
21 or an employee, attorney, or actuary of an insurer, may
22 negotiate and obtain reinsurance for that insurer
23 without holding a license as a broker or a manager or
24 being required to use the services of a broker or
25 manager if that insurer, employee, attorney, or
26 actuary does not otherwise hold himself out as a broker
27 or manager or perform the duties or provide the
28 services of a broker or manager.

29 Revised Law

30 Sec. 4152.252. AUDITED STATEMENT OF MANAGER'S FINANCIAL
31 CONDITION. An insurer shall obtain annually an audited statement
32 as provided by Section 4152.210 of the financial condition of each
33 manager with whom the insurer transacts business. (V.T.I.C.
34 Art. 21.07-7, Sec. 8(b) (part).)

35 Source Law

36 (b) The insurer annually shall obtain a copy of
37 audited statements of the financial condition of each
38 manager that the insurer engages. . . .

39 Revised Law

40 Sec. 4152.253. REVIEW OF UNDERWRITING AND CLAIMS PROCESSING
41 OPERATIONS. An insurer shall conduct at least semiannually an

1 on-site review of the underwriting and claims processing operations
2 of a manager with whom the insurer enters into a contract under
3 Section 4152.201. (V.T.I.C. Art. 21.07-7, Sec. 6(n).)

4 Source Law

5 (n) The insurer shall conduct semiannually or
6 more often an on-site review of the underwriting and
7 claims processing operations of the manager.

8 Revised Law

9 Sec. 4152.254. AUTHORITY FOR RETROCESSIONAL CONTRACTS OR
10 PARTICIPATION IN REINSURANCE SYNDICATES. Binding authority for
11 all retrocessional contracts or participation in reinsurance
12 syndicates rests with an officer of the insurer. That officer may
13 not be affiliated with a manager acting for the insurer. (V.T.I.C.
14 Art. 21.07-7, Sec. 8(c).)

15 Source Law

16 (c) Binding authority for all retrocessional
17 contracts or participation in reinsurance syndicates
18 rests with an officer of the insurer. That officer may
19 not be affiliated with the manager acting for the
20 insurer.

21 Revised Law

22 Sec. 4152.255. NOTIFICATION OF TERMINATION OF MANAGER'S
23 CONTRACT. (a) Not later than the 30th day after the date an insurer
24 terminates a manager's contract, the insurer shall provide written
25 notice to the commissioner of the termination, including the
26 reasons for termination.

27 (b) The notice is a privileged communication and is not
28 subject to public disclosure or admission into evidence in any
29 proceeding. (V.T.I.C. Art. 21.07-7, Sec. 8(d).)

30 Source Law

31 (d) Not later than the 30th day after the date of
32 termination by an insurer of a manager's contract, the
33 insurer shall provide written notification of the
34 termination, including the reasons for termination, to
35 the commissioner. The written notification is a
36 privileged communication and is not subject to public
37 disclosure or admission in evidence in any proceeding.

38 Revised Law

39 Sec. 4152.256. APPOINTMENT OF CERTAIN PERSONS TO BOARD OF
40 DIRECTORS PROHIBITED. (a) This section does not apply to a

1 relationship governed by Chapter 823.

2 (b) An insurer may not appoint to the insurer's board of
3 directors an officer, director, employee, controlling shareholder,
4 or submanager of a manager acting for that insurer. (V.T.I.C.
5 Art. 21.07-7, Sec. 8(e).)

6 Source Law

7 (e) An insurer may not appoint to its board of
8 directors any officer, director, employee,
9 controlling shareholder, or submanager of a manager
10 acting for that insurer. This subsection does not
11 apply to a relationship governed by Article 21.49-1 of
12 this code.

13 [Sections 4152.257-4152.300 reserved for expansion]

14 SUBCHAPTER G. DISCIPLINE AND ENFORCEMENT

15 Revised Law

16 Sec. 4152.301. GROUNDS FOR LICENSE DENIAL OR DISCIPLINARY
17 ACTION. The department may deny an application for a license or
18 discipline a license holder under Subchapter C, Chapter 4005, if
19 the department determines that the applicant or license holder, or
20 a person who would be authorized to act on behalf of the applicant
21 or license holder under Section 4152.057, has:

22 (1) wilfully violated or participated in the violation
23 of this chapter or another insurance law of this state;

24 (2) intentionally made a material misstatement in the
25 license application;

26 (3) obtained or attempted to obtain the license by
27 fraud or misrepresentation;

28 (4) misappropriated, converted to the person's own
29 use, or illegally withheld money required to be held in a fiduciary
30 capacity;

31 (5) materially misrepresented the terms or effect of
32 any contract of insurance or reinsurance, or engaged in any
33 fraudulent transaction; or

34 (6) been convicted of a felony or of a misdemeanor of
35 which criminal fraud is an essential element. (V.T.I.C.
36 Art. 21.07-7, Sec. 3(e).)

1 Source Law

2 (e) The department may discipline a license
3 holder or deny an application under Section 5, Article
4 21.01-2, of this code if it determines that the
5 applicant for or holder of a license, or any person who
6 would be authorized to act on behalf of the applicant
7 or the license holder under Subsection (c) of this
8 section has:

9 (1) wilfully violated or participated in
10 the violation of this article or any of the insurance
11 laws of this state;

12 (2) intentionally made a material
13 misstatement in the license application;

14 (3) obtained or attempted to obtain the
15 license by fraud or misrepresentation;

16 (4) misappropriated, converted to his own
17 use, or illegally withheld money required to be held in
18 a fiduciary capacity;

19 (5) materially misrepresented the terms or
20 effect of any contract of insurance or reinsurance, or
21 engaged in any fraudulent transaction; or

22 (6) been convicted of a felony or of any
23 misdemeanor of which criminal fraud is an essential
24 element.

25 Revised Law

26 Sec. 4152.302. IMPOSITION OF SANCTIONS. (a) The
27 commissioner may impose or seek any sanction authorized by law,
28 including the penalties authorized by Chapters 82 and 83, against a
29 reinsurance intermediary, insurer, or reinsurer who the
30 commissioner determines, after notice and hearing as provided by
31 this code, has violated this chapter.

32 (b) The commissioner may impose or seek any sanction
33 authorized by law, including the penalties authorized by Chapter
34 101, against a nonlicensed reinsurance intermediary who violates
35 this chapter. (V.T.I.C. Art. 21.07-7, Sec. 10(a).)

36 Source Law

37 Sec. 10. (a) If, after notice and hearing as
38 provided in this code, the commissioner determines
39 that a reinsurance intermediary, insurer, or reinsurer
40 has violated this article, the commissioner may impose
41 and enforce any sanction authorized by law against the
42 violator, including the penalties imposed under
43 Articles 1.10 and 1.10A of this code. If a nonlicensed
44 reinsurance intermediary violates this article, the
45 commissioner may impose and enforce any sanctions
46 authorized by law against the nonlicensed reinsurance
47 intermediary, including the penalties imposed under
48 Article 1.14-1 of this code.

49 Revisor's Note

50 Section 10(a), V.T.I.C. Article 21.07-7,
51 authorizes the commissioner of insurance to "impose

1 and enforce" certain sanctions. The revised law omits
2 the reference to "enforce" because "enforce" is
3 included in the meaning of "impose." The revised law
4 adds a reference to the commissioner "seeking" those
5 sanctions because some of the referenced sanctions are
6 sought by the commissioner and imposed by another
7 entity. For example, under Section 101.105 of this
8 code, the commissioner is authorized to request that
9 the attorney general institute a civil suit to obtain
10 injunctive relief or recover a civil penalty.

11 Revisor's Note
12 (End of Subchapter)

13 (1) Section 10(b), V.T.I.C. Article 21.07-7,
14 authorizes appeal to a district court in Travis County
15 from a final decision of the commissioner of insurance
16 and provides that review of the decision by the court
17 is subject to the substantial evidence rule. The
18 revised law omits Section 10(b) because the provision
19 is redundant of Subchapter D, Chapter 36, of this code.
20 The omitted law reads:

21 (b) Appeal from a final decision by
22 the commissioner may be made to a district
23 court in Travis County. Review of the
24 commissioner's decision by the district
25 court is subject to the substantial
26 evidence rule.

27 (2) Section 10(c), V.T.I.C. Article 21.07-7,
28 provides that Section 10 does not affect the right of
29 the commissioner of insurance to impose any other
30 penalties authorized by law. The revised law omits
31 that subsection for the reason stated in Revisor's Note
32 (2) to Section 4152.151. The omitted law reads:

33 (c) This section does not affect the
34 right of the commissioner to impose any
35 other penalties authorized by law.

36 CHAPTER 4153. RISK MANAGERS

37 SUBCHAPTER A. GENERAL PROVISIONS

38 Sec. 4153.001. DEFINITION 1996

1 Sec. 4153.002. EXEMPTIONS 1997

2 Sec. 4153.003. RULES 1998

3 [Sections 4153.004-4153.050 reserved for expansion]

4 SUBCHAPTER B. LICENSE REQUIREMENTS

5 Sec. 4153.051. LICENSE REQUIRED. 1998

6 Sec. 4153.052. APPLICATION 1998

7 Sec. 4153.053. QUALIFICATIONS. 1999

8 Sec. 4153.054. EXAMINATION 2000

9 Sec. 4153.055. EXEMPTIONS FROM EXAMINATION REQUIREMENT . . . 2001

10 Sec. 4153.056. REEXAMINATION 2002

11 Sec. 4153.057. FEES. 2002

12 Sec. 4153.058. RECIPROCAL LICENSE 2003

13 Sec. 4153.059. LICENSE EXPIRATION 2004

14 Sec. 4153.060. LICENSE RENEWAL 2004

15 [Sections 4153.061-4153.100 reserved for expansion]

16 SUBCHAPTER C. POWERS AND DUTIES OF RISK MANAGERS

17 Sec. 4153.101. PLACE OF BUSINESS 2005

18 Sec. 4153.102. NOTIFICATION OF CHANGE OF PLACE OF

19 BUSINESS 2005

20 [Sections 4153.103-4153.150 reserved for expansion]

21 SUBCHAPTER D. DISCIPLINARY ACTION

22 Sec. 4153.151. GROUNDS FOR DISCIPLINARY ACTION 2006

23 Sec. 4153.152. LICENSE SUSPENSION 2006

24 Sec. 4153.153. REINSTATEMENT OR REISSUANCE OF LICENSE 2007

25 CHAPTER 4153. RISK MANAGERS

26 SUBCHAPTER A. GENERAL PROVISIONS

27 Revised Law

28 Sec. 4153.001. DEFINITION. In this chapter, "risk

29 manager" means a person who:

30 (1) represents to the public that the person is a risk

31 manager; and

32 (2) for compensation examines or evaluates risks for

33 and provides advice regarding reduction of risks to a person

34 seeking to obtain or renew property and casualty insurance coverage

1 in this state. (V.T.I.C. Art. 21.14-1, Sec. 1(1).)

2 Source Law

3 Art. 21.14-1

4 Sec. 1. In this article:

5 (1) "Risk manager" means a person who
6 holds himself out to the public and who for
7 compensation examines, assesses, or evaluates risks
8 for and provides advice for reduction of risks to a
9 person who seeks to obtain or renew property and
10 casualty insurance coverage in this state.

11 Revisor's Note

12 (1) Section 1, V.T.I.C. Article 21.14-1, refers
13 to a person who "examines, assesses, or evaluates"
14 risks. The revised law omits the reference to
15 "assesses" because "assesses" is included in the
16 meaning of "evaluates."

17 (2) Section 1(2), V.T.I.C. Article 21.14-1,
18 defines "board" as the State Board of Insurance.
19 Chapter 685, Acts of the 73rd Legislature, Regular
20 Session, 1993, abolished the board and transferred its
21 functions to the commissioner of insurance and the
22 Texas Department of Insurance. Throughout this
23 chapter, references to the board have been changed
24 appropriately. For this reason, the revised law omits
25 the definition of "board." The omitted law reads:

26 (2) "Board" means the State
27 Board of Insurance.

28 (3) Section 1(3), V.T.I.C. Article 21.14-1,
29 defines "commissioner" as the commissioner of
30 insurance. The revised law omits the definition as
31 unnecessary because Section 31.001 defines
32 "commissioner" for purposes of this code and the other
33 insurance laws of this state to mean the commissioner
34 of insurance. The omitted law reads:

35 (3) "Commissioner" means the
36 commissioner of insurance.

37 Revised Law

38 Sec. 4153.002. EXEMPTIONS. This chapter does not apply to

1 a person who is employed as a risk manager by:

2 (1) a liability insurance company authorized to engage
3 in business in this state;

4 (2) a single employer; or

5 (3) a public self-insurance pool. (V.T.I.C.
6 Art. 21.14-1, Sec. 3.)

7 Source Law

8 Sec. 3. This article does not apply to a person
9 who is employed as a risk manager by a liability
10 insurance company authorized to do business in this
11 state or by a single employer or by a public
12 self-insured pool.

13 Revised Law

14 Sec. 4153.003. RULES. The commissioner may adopt rules
15 necessary to carry out this chapter and to regulate risk managers.
16 (V.T.I.C. Art. 21.14-1, Sec. 15.)

17 Source Law

18 Sec. 15. The board may adopt necessary rules to
19 carry out this article and to regulate risk managers.

20 [Sections 4153.004-4153.050 reserved for expansion]

21 SUBCHAPTER B. LICENSE REQUIREMENTS

22 Revised Law

23 Sec. 4153.051. LICENSE REQUIRED. A person may not act as
24 or represent that the person is a risk manager in this state unless
25 the person:

26 (1) meets the requirements prescribed by this chapter
27 and department rules; and

28 (2) holds a license issued by the department.
29 (V.T.I.C. Art. 21.14-1, Sec. 2.)

30 Source Law

31 Sec. 2. A person may not act as or hold himself
32 out to be a risk manager in this state unless the
33 person meets the requirements of this article and
34 rules of the board and is licensed by the board.

35 Revised Law

36 Sec. 4153.052. APPLICATION. (a) To obtain a license to
37 act as a risk manager in this state, an applicant must submit to the
38 department an application on forms prescribed by the commissioner

1 and provided by the department.

2 (b) An application must be accompanied by the license fee
3 required by Section 4153.057 and include:

4 (1) information the department requires relating to
5 the applicant's identity, personal history, experience, and
6 business record; and

7 (2) any other information the department requires.

8 (V.T.I.C. Art. 21.14-1, Secs. 4, 7(b).)

9 Source Law

10 Sec. 4. (a) A person who desires to be licensed
11 as a risk manager in this state shall submit an
12 application to the board on forms prescribed and
13 furnished by the board.

14 (b) As part of the application, the applicant
15 shall furnish to the board any information relating to
16 the applicant's identity, personal history,
17 experience, business record, or other items as the
18 board may require.

19 [Sec. 7]

20 (b) The license fee required by Subsection (a)
21 of this section shall accompany the application for
22 the initial license.

23 Revised Law

24 Sec. 4153.053. QUALIFICATIONS. To qualify for a risk
25 manager's license, an applicant must:

26 (1) be at least 18 years of age;

27 (2) maintain a place of business in this state;

28 (3) meet the application requirements prescribed by
29 this chapter and department rules;

30 (4) take and pass the examination required by this
31 chapter; and

32 (5) pay the examination and license fees. (V.T.I.C.
33 Art. 21.14-1, Sec. 5.)

34 Source Law

35 Sec. 5. To qualify for a license under this
36 article, a person must:

37 (1) be at least 18 years of age;

38 (2) maintain a place of business in this
39 state;

40 (3) meet the application requirements
41 required by this article and rules of the board;

42 (4) take and pass the licensing
43 examination; and

44 (5) pay the examination and licensing

1 fees.

2 Revised Law

3 Sec. 4153.054. EXAMINATION. (a) Except as provided by
4 Sections 4153.055 and 4153.058, an applicant for a risk manager's
5 license must personally take and pass an examination to the
6 satisfaction of the commissioner under this chapter and department
7 rules.

8 (b) The commissioner shall prescribe the examination for a
9 risk manager's license. The examination must:

10 (1) be designed to test the qualifications and
11 competency of the applicant to be a risk manager; and

12 (2) be of sufficient scope to reasonably test the
13 applicant's knowledge of risk management and the duties and
14 responsibilities of a risk manager under the laws of this state and
15 department rules.

16 (c) The department shall:

17 (1) determine the times and places for examinations;
18 and

19 (2) give reasonable public notice of the examinations
20 in the manner provided by department rules. (V.T.I.C.
21 Art. 21.14-1, Secs. 6(a), (c), (d), (e).)

22 Source Law

23 Sec. 6. (a) Except as provided by Subsection
24 (b) of this section, each applicant for a risk
25 manager's license must personally take and pass an
26 examination to the satisfaction of the commissioner
27 under this article and rules of the board.

28 (c) The board shall prescribe the examination to
29 be taken by applicants for a risk manager's license.

30 (d) The examination shall be designed to test
31 the qualifications and competency of each applicant to
32 be a risk manager and shall be of sufficient scope to
33 reasonably test each applicant's knowledge of risk
34 management and the duties and responsibilities of a
35 risk manager under the laws of this state and rules of
36 the board.

37 (e) The board shall determine the times and
38 places for licensing examinations and shall give
39 reasonable public notice of the examinations in the
40 manner provided by its rules.

41 Revisor's Note

42 Section 6(a), V.T.I.C. Article 21.14-1, requires

1 an applicant for a risk manager's license to take and
2 pass an examination, except as provided by Section
3 6(b) of that article. In addition to that exception,
4 Section 13, V.T.I.C. Article 21.14-1, revised as
5 Section 4153.058, provides another exception to the
6 examination requirement for obtaining a risk manager's
7 license. Accordingly, the revised law includes a
8 cross-reference to Section 4153.058 for the
9 convenience of the reader.

10 Revised Law

11 Sec. 4153.055. EXEMPTIONS FROM EXAMINATION REQUIREMENT. An
12 applicant is not required to take an examination to obtain a risk
13 manager's license if the applicant holds the designation of:

14 (1) chartered property casualty underwriter (CPCU)
15 from the American Institute for Chartered Property Casualty
16 Underwriters;

17 (2) certified insurance counselor (CIC) from the
18 national Society of Certified Insurance Counselors; or

19 (3) associate in risk management (ARM) from the
20 Insurance Institute of America. (V.T.I.C. Art. 21.14-1, Sec.
21 6(b).)

22 Source Law

23 (b) The following persons are not required to
24 take the examination as a prerequisite to obtaining a
25 license under this article:

26 (1) a person who holds the designation
27 Chartered Property and Casualty Underwriter
28 (C.P.C.U.) from the American Institute for Property
29 Liability Underwriters;

30 (2) a person who holds the designation
31 Certified Insurance Counselor (C.I.C.) from the
32 national Society of Certified Insurance Counselors; or

33 (3) a person who holds the designation of
34 associate in risk management from the Insurance
35 Institute of America.

36 Revisor's Note

37 Section 6(b), V.T.I.C. Article 21.14-1, refers to
38 the designation "Chartered Property and Casualty
39 Underwriter (C.P.C.U.) from the American Institute for
40 Property Liability Underwriters." The revised law

1 substitutes "chartered property casualty underwriter
2 (CPCU) from the American Institute for Chartered
3 Property Casualty Underwriters" because that is the
4 proper name of the designation and of the organization
5 that grants it.

6 Revised Law

7 Sec. 4153.056. REEXAMINATION. (a) An applicant who fails
8 the examination may retake the examination on payment of an
9 additional examination fee.

10 (b) The commissioner may require the applicant to wait for a
11 reasonable period determined by the commissioner before the
12 applicant may retake the examination. (V.T.I.C. Art. 21.14-1,
13 Secs. 6(g), (i).)

14 Source Law

15 (g) An applicant who fails an examination may
16 retake the examination on payment of an additional
17 examination fee.

18 (i) If an applicant fails an examination, the
19 commissioner may require the applicant to wait for a
20 reasonable time determined by the commissioner before
21 the applicant is allowed to again take the
22 examination.

23 Revised Law

24 Sec. 4153.057. FEES. (a) The commissioner shall set and
25 collect in advance a nonrefundable fee, in an amount not to exceed
26 \$50, for:

27 (1) an examination required by this chapter if the
28 department administers the examination;

29 (2) a risk manager's license; and

30 (3) the renewal of a risk manager's license.

31 (b) A fee collected under this section shall be deposited to
32 the credit of the Texas Department of Insurance operating account.
33 (V.T.I.C. Art. 21.14-1, Secs. 7(a), (c); 8 (part).)

34 Source Law

35 Sec. 7. (a) The commissioner shall collect in
36 advance the following nonrefundable fees for a risk
37 manager's examination and license:

38 (1) an amount not to exceed \$50 as
39 determined by the board for each examination, if the
40 examination is given by the board; and

1 (2) an amount not to exceed \$50 as
2 determined by the board for a risk manager's license.

3 (c) When collected, the fees required by this
4 article shall be deposited in the state treasury to the
5 credit of the State Board of Insurance operating fund.
6 An expenditure may not be made from this fund except
7 pursuant to legislative appropriation.

8 Sec. 8. . . . [A licensee may renew an
9 unexpired license by . . . paying] the nonrefundable
10 renewal fee, in an amount not to exceed \$50 as
11 determined by the board,

12 Revisor's Note

13 Section 7(c), V.T.I.C. Article 21.14-1, requires
14 fees to be deposited in the state treasury to the
15 credit of the State Board of Insurance operating fund
16 and provides that expenditures may not be made from the
17 fund "except pursuant to legislative appropriation."
18 Under the authority of Chapter 4, Acts of the 72nd
19 Legislature, 1st Called Session, 1991, the Texas
20 Department of Insurance operating fund (the later name
21 of the State Board of Insurance operating fund) was
22 converted to an account in the general revenue fund.
23 The revised law is drafted accordingly. In addition,
24 the revised law omits the requirement of a legislative
25 appropriation for expenditures as unnecessary because
26 under Section 6, Article VIII, Texas Constitution,
27 money in the treasury may be spent only as provided by
28 a specific appropriation.

29 Revised Law

30 Sec. 4153.058. RECIPROCAL LICENSE. On submission of an
31 application and the license fee required by Section 4153.057, a
32 person may receive a risk manager's license without examination if
33 the person is licensed as a risk manager by another state, the
34 licensing requirements of which were, on the date the license was
35 issued, substantially equivalent to the requirements prescribed by
36 this chapter. (V.T.I.C. Art. 21.14-1, Sec. 13.)

37 Source Law

38 Sec. 13. A person who is licensed as a risk
39 manager by another state, the District of Columbia, or
40 a commonwealth or territory of the United States,

1 whose requirements for licensing were on the date of
2 the licensing substantially equal to those prescribed
3 by this article, may receive a license without
4 examination on submission of an application form and
5 payment of the licensing fee required by Section 7 of
6 this article.

7 Revisor's Note

8 Section 13, V.T.I.C. Article 21.14-1, refers to
9 "another state, the District of Columbia, or a
10 commonwealth or territory of the United States." The
11 revised law omits the references to "the District of
12 Columbia" and "a commonwealth or territory of the
13 United States" because those terms are included in the
14 definition of "state" provided by Section 311.005(7),
15 Government Code (Code Construction Act), applicable to
16 the revised law.

17 Revised Law

18 Sec. 4153.059. LICENSE EXPIRATION. Except as otherwise
19 provided by a staggered renewal system adopted under Section
20 4003.002, a risk manager's license expires on the second
21 anniversary of the date the license was issued. (V.T.I.C.
22 Art. 21.14-1, Sec. 8 (part).)

23 Source Law

24 Sec. 8. Except as provided by a staggered
25 renewal system adopted under Article 21.01-2 of this
26 code, a license issued under this article expires two
27 years after the date of issuance. . . .

28 Revised Law

29 Sec. 4153.060. LICENSE RENEWAL. (a) A license holder may
30 renew an unexpired license by:

31 (1) filing with the department a completed renewal
32 application; and

33 (2) paying the nonrefundable renewal fee.

34 (b) The commissioner shall issue a renewal certificate to
35 the license holder if the commissioner determines the license
36 holder continues to be eligible for the license. (V.T.I.C.
37 Art. 21.14-1, Sec. 8 (part).)

1 [Sections 4153.103-4153.150 reserved for expansion]

2 SUBCHAPTER D. DISCIPLINARY ACTION

3 Revised Law

4 Sec. 4153.151. GROUNDS FOR DISCIPLINARY ACTION. The
5 department may discipline a license holder or deny an applicant a
6 license under Subchapter C, Chapter 4005:

7 (1) for any cause for which, if known by the
8 department, issuance of the license could have been refused; or

9 (2) if the license holder or applicant:

10 (A) wilfully or knowingly violates this chapter,
11 an insurance law of this state, or a department rule;

12 (B) obtains or attempts to obtain a license
13 through wilful misrepresentation or fraud;

14 (C) fails the examination required by this
15 chapter; or

16 (D) is convicted on final judgment of a felony.
17 (V.T.I.C. Art. 21.14-1, Sec. 10.)

18 Source Law

19 Sec. 10. The department may discipline a risk
20 manager or deny an application under Section 5,
21 Article 21.01-2, of this code:

22 (1) for any cause for which issuance of the
23 license could have been refused had it been known to
24 the board;

25 (2) if the licensee wilfully violates or
26 knowingly participates in the violation of this
27 article, any insurance law of this state, or rules of
28 the board;

29 (3) if the licensee has obtained or
30 attempted to obtain a license through wilful
31 misrepresentation or fraud, or has failed to pass the
32 examination required under this article; or

33 (4) if a licensee is convicted, by final
34 judgment, of a felony.

35 Revised Law

36 Sec. 4153.152. LICENSE SUSPENSION. (a) An order
37 suspending a license must specify the duration of the suspension
38 period. The department may not suspend a license for a period of
39 more than 12 months.

40 (b) A license holder whose license is revoked or suspended
41 shall surrender the license to the commissioner at the

1 commissioner's request. (V.T.I.C. Art. 21.14-1, Sec. 11.)

2 Source Law

3 Sec. 11. (a) Every order suspending a license
4 must specify the period during which the suspension is
5 effective. A license may not be suspended for a period
6 to exceed 12 months.

7 (b) The holder of a license that has been
8 revoked or suspended shall surrender the license to
9 the commissioner at his request.

10 Revised Law

11 Sec. 4153.153. REINSTATEMENT OR REISSUANCE OF
12 LICENSE. The commissioner may not reinstate the license of or
13 reissue a license to a person whose license is suspended or revoked
14 or to whom the department refuses to issue a renewal certificate
15 until the first anniversary of the date of the suspension,
16 revocation, or refusal to renew. (V.T.I.C. Art. 21.14-1, Sec. 12.)

17 Source Law

18 Sec. 12. The commissioner may not reinstate the
19 license of, or reissue a license to, a licensee or
20 former licensee whose license has been suspended,
21 revoked, or the renewal of which has been refused for
22 one year from the date of suspension, revocation, or
23 refusal to renew.

1 APPENDIX A

2 CONFORMING AMENDMENTS

3 SECTION 8. CONFORMING AMENDMENT. Article 1.10, Insurance
4 Code, is amended to read as follows:

5 Art. 1.10. CERTAIN DUTIES OF THE DEPARTMENT. In addition
6 to the other duties required of the department, the department
7 shall perform duties as follows:

8 2. File Articles of Incorporation and Other Papers.
9 File and preserve in its office all acts or articles of
10 incorporation of insurance companies and all other papers required
11 by law to be deposited with the Department and, upon application of
12 any party interested therein, furnish certified copies thereof upon
13 payment of the fees prescribed by law.

14 3. Shall Calculate Reserve. For every company
15 transacting any kind of insurance business in this State, for which
16 no basis is prescribed by law, the Department shall calculate the
17 reinsurance reserve upon the same basis prescribed in Section
18 862.102 of this code as to companies transacting fire insurance
19 business.

20 4. To Calculate Re-insurance Reserve. On the
21 thirty-first day of December of each and every year, or as soon
22 thereafter as may be practicable, the Department shall have
23 calculated in the Department the re-insurance reserve for all
24 unexpired risks of all insurance companies organized under the laws
25 of this state, or transacting business in this state, transacting
26 any kind of insurance other than life, fire, marine, inland,
27 lightning or tornado insurance, which calculation shall be in
28 accordance with the provisions of Paragraph 3 hereof.

29 5. When a Company's Surplus is Impaired. No impairment
30 of the capital stock of a stock company shall be permitted. No
31 impairment of the surplus of a stock company, or of the minimum
32 required aggregate surplus of a mutual, Lloyd's, or reciprocal
33 insurer, shall be permitted in excess of that provided by this
34 section. Having charged against a company other than a life

1 insurance company, the reinsurance reserve, as prescribed by the
2 laws of this State, and adding thereto all other debts and claims
3 against the company, the Commissioner shall, (i) if it is
4 determined that the surplus required by Section 822.054, 822.202,
5 822.203, 822.205, 822.210, 822.211, or 822.212 of this code of a
6 stock company doing the kind or kinds of insurance business set out
7 in its Certificate of Authority is impaired to the extent of more
8 than fifty (50%) per cent of the required surplus for a capital
9 stock insurance company, or is less than the minimum level of
10 surplus required by Commissioner promulgated risk-based capital
11 and surplus regulations, or (ii) if it is determined that the
12 required aggregate surplus of a reciprocal or mutual company, or
13 the required aggregate of guaranty fund and surplus of a Lloyd's
14 company, other than a life insurance company, doing the kind or
15 kinds of insurance business set out in its Certificate of Authority
16 is impaired to the extent of more than twenty-five per cent (25%) of
17 the required aggregate surplus, or is less than the minimum level of
18 surplus required by Commissioner promulgated risk-based capital
19 and surplus regulations, the Commissioner shall order the company
20 to remedy the impairment of surplus to acceptable levels specified
21 by the Commissioner or to cease to do business within this State.
22 The Commissioner shall thereupon immediately institute such
23 proceedings as may be necessary to determine what further actions
24 shall be taken in the case.

25 6. Shall Publish Results of Investigation. The
26 Department shall publish the result of an examination of the
27 affairs of any company whenever the Commissioner deems it for the
28 interest of the public.

29 17. Voluntary Deposits. (a) In the event any
30 insurance company organized and doing business under the provisions
31 of this Code shall be required by any other state, country or
32 province as a requirement for permission to do an insurance
33 business therein to make or maintain a deposit with an officer of
34 any state, country, or province, such company, at its discretion,

1 may voluntarily deposit with the Comptroller such securities as may
2 be approved by the Commissioner of Insurance to be of the type and
3 character authorized by law to be legal investments for such
4 company, or cash, in any amount sufficient to enable it to meet such
5 requirements. The Comptroller is hereby authorized and directed to
6 receive such deposit and hold it exclusively for the protection of
7 all policyholders or creditors of the company wherever they may be
8 located, or for the protection of the policyholders or creditors of
9 a particular state, country or province, as may be designated by
10 such company at the time of making such deposit. The company may,
11 at its option, withdraw such deposit or any part thereof, first
12 having deposited with the Comptroller, in lieu thereof, other
13 securities of like class and of equal amount and value to those
14 withdrawn, which withdrawal and substitution must be approved by
15 the Commissioner of Insurance. The proper officer of each
16 insurance company making such deposit shall be permitted at all
17 reasonable times to examine such securities and to detach coupons
18 therefrom, and to collect interest thereon, under such reasonable
19 rules and regulations as may be prescribed by the Comptroller and
20 the Commissioner of Insurance. Any deposit so made for the
21 protection of policyholders or creditors of a particular state,
22 country or province shall not be withdrawn, except by substitution
23 as provided above, by the company, except upon filing with the
24 Commissioner of Insurance evidence satisfactory to him that the
25 company has withdrawn from business, and has no unsecured
26 liabilities outstanding or potential policyholder liabilities or
27 obligations in such other state, country or province requiring such
28 deposit, and upon the filing of such evidence the company may
29 withdraw such deposit at any time upon the approval of the
30 Commissioner of Insurance. Any deposit so made for the protection
31 of all policyholders or creditors wherever they may be located
32 shall not be withdrawn, except by substitution as provided above,
33 by the company except upon filing with the Commissioner of
34 Insurance evidence satisfactory to him that the company does not

1 have any unsecured liabilities outstanding or potential policy
2 liabilities or obligations anywhere, and upon filing such evidence
3 the company may withdraw such deposit upon the approval of the
4 Commissioner of Insurance. For the purpose of state, county and
5 municipal taxation, the situs of any securities deposited with the
6 Comptroller hereunder shall be in the city and county where the
7 principal business office of such company is fixed by its charter.

8 (b) Any voluntary deposit held by the Comptroller or
9 the Department heretofore made by any insurance company in this
10 State, and which deposit was made for the purpose of gaining
11 admission to another state, may be considered, at the option of such
12 company, to be hereinafter held under the provisions of this Act.

13 (c) When two or more companies merge or consolidate or
14 enter a total reinsurance contract by which the ceding company is
15 dissolved and its assets acquired and liabilities assumed by the
16 surviving company, and the companies have on deposit with the
17 Comptroller two or more deposits made for identical purposes under
18 this section or Article 4739, Revised Statutes, as amended, and now
19 repealed, all such deposits, except the deposit of greatest amount
20 and value, may be withdrawn by the new surviving or reinsuring
21 company, upon proper showing of duplication of such deposits and
22 that the company is the owner thereof.

23 (d) Any company which has made a deposit or deposits
24 under this section or Article 4739, Revised Statutes, as amended
25 and now repealed, shall be entitled to a return of such deposits
26 upon proper application therefor and a showing before the
27 Commissioner that such deposit or deposits are no longer required
28 under the laws of any state, country or province in which such
29 company sought or gained admission to do business upon the strength
30 of a certificate of such deposit.

31 (e) Upon being furnished a certified copy of the
32 Commissioner's order issued under Subsection (c) or (d) above, the
33 Comptroller shall release, transfer and deliver such deposit or
34 deposits to the owner as directed in said order.

1 ~~[18. Complaint File. The Department shall keep an~~
2 ~~information file about each complaint filed with the Department~~
3 ~~concerning an activity that is regulated by the Department or~~
4 ~~Commissioner.~~

5 ~~[19. Notice of Complaint Status. If a written~~
6 ~~complaint is filed with the Department, the Department, at least~~
7 ~~quarterly and until final disposition of the complaint, shall~~
8 ~~notify the parties to the complaint of the status of the complaint~~
9 ~~unless the notice would jeopardize an undercover investigation.~~

10 ~~[20. Electronic Transfer of Funds. The Commissioner~~
11 ~~shall adopt rules for the electronic transfer of any taxes, fees,~~
12 ~~guarantee funds, or other money owed to or held for the benefit of~~
13 ~~the state and for which the Department has the responsibility to~~
14 ~~administer under this code or another insurance law of this state.~~
15 ~~The Commissioner shall require the electronic transfer of any~~
16 ~~amounts held or owed in an amount exceeding \$500,000.]~~

17 SECTION 9. CONFORMING AMENDMENT. Chapter 30, Insurance
18 Code, is amended to read as follows:

19 CHAPTER 30. GENERAL PROVISIONS

20 Sec. 30.001. PURPOSE OF TITLES 2, 3, 5, 6, 7, [AND] 8, 9, 11,
21 AND 13. (a) This title and Titles 3, 5, 6, 7, [and] 8, 9, 11, and 13
22 are enacted as a part of the state's continuing statutory revision
23 program, begun by the Texas Legislative Council in 1963 as directed
24 by the legislature in the law codified as Section 323.007,
25 Government Code. The program contemplates a topic-by-topic
26 revision of the state's general and permanent statute law without
27 substantive change.

28 (b) Consistent with the objectives of the statutory
29 revision program, the purpose of this title and Titles 3, 5, 6, 7,
30 [and] 8, 9, 11, and 13 is to make the law encompassed by the titles
31 more accessible and understandable by:

32 (1) rearranging the statutes into a more logical
33 order;

34 (2) employing a format and numbering system designed

1 to facilitate citation of the law and to accommodate future
2 expansion of the law;

3 (3) eliminating repealed, duplicative,
4 unconstitutional, expired, executed, and other ineffective
5 provisions; and

6 (4) restating the law in modern American English to
7 the greatest extent possible.

8 Sec. 30.002. CONSTRUCTION. Except as provided by Section
9 30.003 and as otherwise expressly provided in this code, Chapter
10 311, Government Code (Code Construction Act), applies to the
11 construction of each provision in this title and in Titles 3, 5, 6,
12 7, ~~and~~ 8, 9, 11, and 13.

13 Sec. 30.003. DEFINITION OF PERSON. The definition of
14 "person" assigned by Section 311.005, Government Code, does not
15 apply to any provision in this title or in Title 3, 5, 6, 7, ~~or~~ 8,
16 9, 11, or 13.

17 Sec. 30.004. REFERENCE IN LAW TO STATUTE REVISED BY TITLE 2,
18 3, 5, 6, 7, ~~OR~~ 8, 9, 11, OR 13. A reference in a law to a statute
19 or a part of a statute revised by this title or by Title 3, 5, 6, 7,
20 ~~or~~ 8, 9, 11, or 13 is considered to be a reference to the part of
21 this code that revises that statute or part of that statute.

22 SECTION 10. CONFORMING AMENDMENT. Subchapter B, Chapter
23 36, Insurance Code, is amended by adding Section 36.108 to read as
24 follows:

25 Sec. 36.108. FILING DATE OF REPORT, FINANCIAL STATEMENT, OR
26 PAYMENT DELIVERED BY POSTAL SERVICE. Except as otherwise
27 specifically provided, for a report, financial statement, or
28 payment that is required to be filed or made in the offices of the
29 commissioner and that is delivered by the United States Postal
30 Service to the offices of the commissioner after the date on which
31 the report, financial statement, or payment is required to be filed
32 or made, the date of filing or payment is the date of:

33 (1) the postal service postmark stamped on the cover
34 in which the report, financial statement, or payment is mailed; or

1 (2) any other evidence of mailing authorized by the
2 postal service reflected on the cover in which the report,
3 financial statement, or payment is mailed. (V.T.I.C. Art. 1.11
4 (part), as amended Acts 77th Leg., R.S., Ch. 1419.)

5 Source Law

6 Art. 1.11. If any report, financial statement,
7 or payment required to be filed or deposited in the
8 offices of the commissioner, or . . . is delivered by
9 the United States Postal Service to the offices of the
10 commissioner or . . . , as required, after the
11 prescribed date on which the report, financial
12 statement, . . . or payment is to be filed, the date of
13 the United States Postal Service postmark stamped on
14 the cover in which the document is mailed, or any other
15 evidence of mailing authorized by the United States
16 Postal Service reflected on the cover in which the
17 document is mailed, shall be deemed to be the date of
18 filing, unless otherwise specifically made an
19 exception to this general statute.

20 SECTION 11. CONFORMING AMENDMENT. Subchapter B, Chapter
21 36, Insurance Code, is amended by adding Section 36.109 to read as
22 follows:

23 Sec. 36.109. RENEWAL EXTENSION FOR CERTAIN PERSONS
24 PERFORMING MILITARY SERVICE. (a) The department may extend the
25 renewal period for a license, permit, certificate of authority,
26 certificate of registration, or other authorization issued by the
27 department to engage in an activity regulated under this code or
28 other insurance laws of this state for a person who is unable in a
29 timely manner to comply with renewal requirements, including any
30 applicable continuing education requirements, because the person
31 was on active duty in a combat theater of operations in the United
32 States armed forces.

33 (b) A person must submit a written application for an
34 extension under this section to the department.

35 (c) The department shall exempt a person who receives an
36 extension under this section from any increased fee or other
37 penalty otherwise imposed for failure to renew in a timely manner.

38 (d) The commissioner may adopt rules as necessary to
39 implement this section. (V.T.I.C. Art. 1.10-1.)

1 pendency of the appeal. An insurer shall use the rate provided in
2 the order while the appeal is pending.

3 (b) The rate is lawful and valid during the appeal, and an
4 insurer may not be required to make any refund from that rate after
5 a decision on the appeal is rendered.

6 (c) If the order is vacated on appeal, the rate established
7 by the commissioner before the vacated order was rendered remains
8 in effect from the date of remand until the commissioner makes a
9 further determination. The commissioner shall consider the court's
10 order in setting a future rate. (V.T.I.C. Art. 1.35A, Sec. 5(d).)

11 Source Law

12 (d) Any order of the commissioner which
13 determines, approves, or sets a rate under this code
14 and is appealed shall be and remain in effect during
15 the pendency of an appeal. During the pendency of the
16 appeal, an insurer shall use the rate provided in the
17 order being appealed. Such rate shall be lawful and
18 valid during such appeal, and an insurer shall not be
19 required to make any refund therefrom after a decision
20 on the appeal. If a decision on appeal shall vacate
21 the order, the rate established by the commissioner
22 prior to the rendition of the vacated order shall be in
23 effect from and after the date of remand and until the
24 commissioner shall make a further determination;
25 however, the commissioner shall consider the order of
26 the court in setting future rates.

27 SECTION 13. CONFORMING AMENDMENT. Section 101.053(b),
28 Insurance Code, is amended to read as follows:

29 (b) Sections 101.051 and 101.052 do not apply to:

30 (1) the lawful transaction of surplus lines insurance
31 under Chapter 981;

32 (2) the lawful transaction of reinsurance by insurers;

33 (3) a transaction in this state that:

34 (A) involves a policy that:

35 (i) is lawfully solicited, written, and
36 delivered outside this state; and

37 (ii) covers, at the time the policy is
38 issued, only subjects of insurance that are not resident, located,
39 or expressly to be performed in this state; and

40 (B) takes place after the policy is issued;

41 (4) a transaction:

1 (A) that involves an insurance contract
2 independently procured through negotiations occurring entirely
3 outside this state;

4 (B) that is reported; and

5 (C) on which premium tax is paid in accordance
6 with Chapter 226 [~~this chapter~~];

7 (5) a transaction in this state that:

8 (A) involves group life, health, or accident
9 insurance, other than credit insurance, and group annuities in
10 which the master policy for the group was lawfully issued and
11 delivered in a state in which the insurer or person was authorized
12 to do insurance business; and

13 (B) is authorized by a statute of this state;

14 (6) an activity in this state by or on the sole behalf
15 of a nonadmitted captive insurance company that insures solely:

16 (A) directors' and officers' liability insurance
17 for the directors and officers of the company's parent and
18 affiliated companies;

19 (B) the risks of the company's parent and
20 affiliated companies; or

21 (C) both the individuals and entities described
22 by Paragraphs (A) and (B);

23 (7) the issuance of a qualified charitable gift
24 annuity under Chapter 102; or

25 (8) a lawful transaction by a servicing company of the
26 Texas workers' compensation employers' rejected risk fund under
27 Section 4.08, Article 5.76-2, as that article existed before its
28 repeal.

29 SECTION 14. CONFORMING AMENDMENT. Section 101.103(a),
30 Insurance Code, is amended to read as follows:

31 (a) If the commissioner has reason to believe a person,
32 including an insurer, has violated or is threatening to violate
33 this chapter or Chapter 226 or a rule adopted under this chapter or
34 Chapter 226, or that a person, including an insurer, violating this

1 chapter or Chapter 226 has engaged in or is threatening to engage in
2 an unfair act, the commissioner may:

- 3 (1) issue a cease and desist order under Subchapter D;
- 4 (2) seek injunctive relief under Section 101.105;
- 5 (3) request the attorney general to recover a civil
6 penalty under Section 101.105; or
- 7 (4) take any combination of those actions.

8 SECTION 15. CONFORMING AMENDMENT. Sections 101.105(a) and
9 (b), Insurance Code, are amended to read as follows:

10 (a) A person or entity, including an insurer, that violates
11 this chapter or Chapter 226 is subject to a civil penalty of not
12 more than \$10,000 for each act of violation and for each day of
13 violation.

14 (b) The commissioner may request that the attorney general
15 institute a civil suit in a district court in Travis County for
16 injunctive relief to restrain a person or entity, including an
17 insurer, from continuing a violation or threat of violation
18 described by Section 101.103(a). On application for injunctive
19 relief and a finding that a person or entity, including an insurer,
20 is violating or threatening to violate this chapter or Chapter 226,
21 the district court shall grant the injunctive relief and issue an
22 injunction without bond.

23 SECTION 16. CONFORMING AMENDMENT. Section 101.201(b),
24 Insurance Code, is amended to read as follows:

25 (b) This section does not apply to insurance procured by a
26 licensed surplus lines agent from an eligible surplus lines insurer
27 as defined by Chapter 981 [~~Article 1.14-2~~] and independently
28 procured contracts of insurance, as described in Section
29 101.053(b)(4), that are reported and on which premium tax is paid in
30 accordance with Chapter 225 or 226 [~~this chapter or Article~~
31 ~~1.14-2~~].

32 SECTION 17. CONFORMING AMENDMENT. Subchapter C, Chapter
33 841, Insurance Code, is amended by adding Section 841.104 to read as
34 follows:

1 upon such policies, shall, before it may again obtain a
2 certificate of authority to transact the business of
3 life insurance in this State, report under oath to the
4 Board of Insurance Commissioners the gross amount of
5 premiums so collected from citizens of this State upon
6 policies of insurance during each calendar year since
7 the end of the period covered by the last preceding
8 report by such company of gross premium receipts upon
9 which it paid an occupation tax, and shall pay to the
10 State a sum equal to the percentage of its gross
11 premium receipts for each such year that was required
12 by law to be paid as occupation taxes by companies
13 doing business in this State, during such year or
14 years; and, upon the payment of such sum and securing a
15 certificate of authority to do business in this State,
16 the penalties provided for the failure to pay such
17 taxes and make such report in the past shall be
18 remitted.

19 Revisor's Note

20 (1) V.T.I.C. Article 3.59 refers to a life
21 insurance company "engaged in writing policies of
22 insurance upon the lives of citizens of this State."
23 The revised law substitutes "residents" for "citizens"
24 because, in the context of that article, the terms are
25 synonymous and the former is more commonly used. In
26 addition, the revised law substitutes "engage in the
27 business of life insurance in this state" for "writing
28 policies of insurance upon the lives" of residents of
29 this state because engaging in the business of life
30 insurance in this state necessarily involves writing
31 policies on the lives of residents of this state.

32 (2) V.T.I.C. Article 3.59 refers to the "Board
33 of Insurance Commissioners." Under Chapter 499, Acts
34 of the 55th Legislature, Regular Session, 1957,
35 administration of the insurance laws of this state was
36 reorganized and the powers and duties of the Board of
37 Insurance Commissioners were transferred to the State
38 Board of Insurance. Chapter 685, Acts of the 73rd
39 Legislature, Regular Session, 1993, abolished the
40 State Board of Insurance and transferred its functions
41 to the commissioner of insurance and the Texas
42 Department of Insurance, as appropriate. Therefore,
43 the revised law substitutes "department" for "Board of

1 Insurance Commissioners."

2 SECTION 18. CONFORMING AMENDMENT. The heading to
3 Subchapter C, Chapter 982, Insurance Code, is amended to read as
4 follows:

5 SUBCHAPTER C. [~~REQUIREMENTS FOR~~] CERTIFICATE OF AUTHORITY

6 SECTION 19. CONFORMING AMENDMENT. Subchapter C, Chapter
7 982, Insurance Code, is amended by adding Section 982.114 to read as
8 follows:

9 Sec. 982.114. PAYMENT OF TAX BY FOREIGN OR ALIEN LIFE
10 INSURANCE COMPANY. (a) A foreign or alien life insurance company
11 that obtains a certificate of authority under this subchapter on or
12 after April 2, 1909, accepts that certificate and agrees to engage
13 in the business of insurance in this state subject to a requirement
14 that, if the company ceases to transact new insurance business in
15 this state but continues to collect renewal premiums from residents
16 of this state, the company shall continue to pay an occupation tax
17 based on gross premiums for each year from residents of this state.

18 (b) The rate of the tax imposed by this section may not
19 exceed the rate imposed by law on insurance companies transacting
20 new insurance business in this state.

21 (c) The foreign or alien life insurance company shall pay
22 the tax and make reports relating to its gross premium receipts in
23 the same manner as a foreign or alien life insurance company that is
24 transacting new insurance business in this state.

25 (d) The foreign or alien life insurance company is subject
26 to examination by the department or by a department designee in the
27 same manner and to the same extent as a company that is transacting
28 new insurance business in this state. (V.T.I.C. Art. 3.25 (part).)

29 Source Law

30 Art. 3.25. Each life insurance company not
31 organized under the laws of this State, hereafter
32 granted a certificate of authority to transact
33 business in this State, shall be deemed to have
34 accepted such certificate and to transact such
35 business hereunder subject to the conditions and
36 requirements that, after it shall cease to transact
37 new business in this State under a certificate of
38 authority, and so long as it shall continue to collect

1 renewal premiums from citizens of this State, it shall
2 be subject to the payment of the same occupation tax in
3 proportion to its gross premiums during any year, from
4 citizens of this State, as is or may be imposed by law
5 on such companies transacting new business within this
6 State, under certificates of authority during such
7 year. The rate of such tax to be so paid by any such
8 company shall never exceed the rate imposed by law upon
9 insurance companies transacting business in this
10 State. Each such company shall make the same reports
11 of its gross premium receipts for each such year and
12 within the same period as is or may be required of such
13 companies holding certificates of authority and shall
14 at all times be subject to examination by the Board of
15 Insurance Commissioners or some one selected by it for
16 that purpose, in the same way and to the same extent as
17 is or may be required of companies transacting new
18 business under certificates of authority in this
19 State, the expenses of such examination to be paid by
20 the company examined. . . .

21 Revisor's Note

22 (1) V.T.I.C. Article 3.25 refers to a life
23 insurance company "not organized under the laws of
24 this State." The revised law substitutes a reference
25 to a "foreign or alien" life insurance company for
26 consistency with the terms used in Chapter 982,
27 Insurance Code. Section 982.001, Insurance Code,
28 defines an "alien insurance company" to mean an
29 insurance company organized under the laws of a
30 foreign country and "foreign insurance company" to
31 mean an insurance company organized under the laws of
32 another state.

33 (2) V.T.I.C. Article 3.25 refers to a company
34 "hereafter" granted a certificate of authority. The
35 revised law substitutes "on or after April 2, 1909,"
36 the effective date of the law from which Article 3.25
37 was derived, for "hereafter."

38 (3) V.T.I.C. Article 3.25 refers to "citizens of
39 this State." The revised law substitutes "residents"
40 for "citizens" because, in the context of that
41 article, the terms are synonymous and the former is
42 more commonly used.

43 (4) V.T.I.C. Article 3.25 refers to the "Board
44 of Insurance Commissioners." Under Chapter 499, Acts

1 of the 55th Legislature, Regular Session, 1957,
2 administration of the insurance laws of this state was
3 reorganized and the powers and duties of the Board of
4 Insurance Commissioners were transferred to the State
5 Board of Insurance. Chapter 685, Acts of the 73rd
6 Legislature, Regular Session, 1993, abolished the
7 State Board of Insurance and transferred its functions
8 to the commissioner of insurance and the Texas
9 Department of Insurance, as appropriate. Therefore,
10 the revised law substitutes "department" for "Board of
11 Insurance Commissioners."

12 (5) V.T.I.C. Article 3.25 provides for
13 examination of a foreign or alien life insurance
14 company with "the expenses of such examination to be
15 paid by the company examined." The revised law omits
16 the quoted language as unnecessary because Section
17 (f), Article 1.16, Insurance Code, requires foreign or
18 alien companies to pay the expenses of an examination.

19 (6) V.T.I.C. Article 3.25 refers to the duties
20 of the board, comptroller, and attorney general in
21 certifying and collecting taxes. The revised law
22 omits the reference to the board (department) because
23 Chapter 685, Acts of the 73rd Legislature, Regular
24 Session, 1993, transferred the department's duties
25 relating to administering and collecting insurance
26 taxes to the comptroller. The revised law omits the
27 reference to the comptroller and the attorney general
28 because the duties of those officers in collecting
29 insurance taxes are specified in other law, including
30 the Insurance Code, the Tax Code, and the Government
31 Code. The omitted law reads:

32 Art. 3.25. . . . The respective
33 duties of the Board in certifying to the
34 amount of such taxes and of the comptroller
35 and Attorney General in their collection
36 shall be the same as are or may be

1 prescribed respecting taxes due from
2 companies authorized to transact new
3 business within this State.

4 SECTION 20. CONFORMING AMENDMENT. Section 181.051, Health
5 and Safety Code, is amended to read as follows:

6 Sec. 181.051. PARTIAL EXEMPTION. Except for Subchapter D,
7 this chapter does not apply to:

8 (1) a covered entity as defined by Section 602.001
9 ~~[licensee as defined in Article 28B.01]~~, Insurance Code;

10 (2) an entity established under Article 5.76-3,
11 Insurance Code; or

12 (3) an employer.

13 SECTION 21. CONFORMING AMENDMENT. Section 403.002(b),
14 Labor Code, is amended to read as follows:

15 (b) The assessment may not exceed an amount equal to two
16 percent of the correctly reported gross workers' compensation
17 insurance premiums, including the modified annual premium of a
18 policyholder that purchases an optional deductible plan under
19 Article 5.55C, Insurance Code. The rate of assessment shall be
20 applied to the modified annual premium before application of a
21 deductible premium credit. (V.T.I.C. Art. 5.68, Sec. (b) (part).)

22 Source Law

23 (b) For purposes of . . . Section 2.22, Texas
24 Workers' Compensation Act (Article 8308-2.22, Vernon's
25 Texas Civil Statutes), gross workers' compensation
26 insurance premiums include the modified annual premium
27 of a policyholder that purchases a deductible pursuant
28 to Article 5.55C of this code, and the rate of
29 assessment shall be applied to the modified annual
30 premium prior to application of any deductible premium
31 credit.

32 SECTION 22. CONFORMING AMENDMENT. Subtitle A, Title 3,
33 Occupations Code, is amended by adding Chapter 107 to read as
34 follows:

35 CHAPTER 107. TELEMEDICINE AND TELEHEALTH

36 Sec. 107.001. DEFINITIONS. In this chapter:

37 (1) "Health professional" and "physician" have the
38 meanings assigned by Section 1455.001, Insurance Code.

39 (2) "Telehealth service" and "telemedicine medical

1 service" have the meanings assigned by Section 57.042, Utilities
2 Code. (V.T.I.C. Art. 21.53F, Secs. 1(2), (3), (4), (5), as added
3 Acts 75th Leg., R.S., Ch. 880.)

4 Source Law

5 Art. 21.53F
6 Sec. 1. In this article:

7 (2) "Health professional" means:

- 8 (A) a physician;
9 (B) an individual who is:

10 (i) licensed or certified in
11 this state to perform health care services; and
12 (ii) authorized to assist a
13 physician in providing telemedicine medical services
14 that are delegated and supervised by the physician; or
15 (C) a licensed or certified health
16 professional acting within the scope of the license or
17 certification who does not perform a telemedicine
18 medical service.

19 (3) "Physician" means a person licensed to
20 practice medicine in this state under Subtitle B,
21 Title 3, Occupations Code.

22 (4) "Telehealth service" has the meaning
23 assigned by Section 57.042, Utilities Code.

24 (5) "Telemedicine medical service" has the
25 meaning assigned by Section 57.042, Utilities Code.

26 Sec. 107.002. INFORMED CONSENT. A treating physician or
27 health professional who provides or facilitates the use of
28 telemedicine medical services or telehealth services shall ensure
29 that the informed consent of the patient, or another appropriate
30 individual authorized to make health care treatment decisions for
31 the patient, is obtained before telemedicine medical services or
32 telehealth services are provided. (V.T.I.C. Art. 21.53F, Sec. 4,
33 as added Acts 75th Leg., R.S., Ch. 880.)

34 Source Law

35 Sec. 4. A treating physician or health
36 professional who provides or facilitates the use of
37 telemedicine medical services or telehealth services
38 shall ensure that the informed consent of the patient,
39 or another appropriate person with authority to make
40 health care treatment decisions for the patient, is
41 obtained before telemedicine medical services or
42 telehealth services are provided.

43 Sec. 107.003. CONFIDENTIALITY. A treating physician or
44 health professional who provides or facilitates the use of
45 telemedicine medical services or telehealth services shall ensure
46 that the confidentiality of the patient's medical information is
47 maintained as required by Chapter 159 or other applicable law.

1 (V.T.I.C. Art. 21.53F, Sec. 5, as added Acts 75th Leg., R.S., Ch.
2 880.)

3 Source Law

4 Sec. 5. A treating physician or health
5 professional who provides or facilitates the use of
6 telemedicine medical services or telehealth services
7 shall ensure that the confidentiality of the patient's
8 medical information is maintained as required by
9 Chapter 159, Occupations Code, or other applicable
10 law.

11 Sec. 107.004. RULES. The Texas State Board of Medical
12 Examiners, in consultation with the commissioner of insurance, as
13 appropriate, may adopt rules necessary to:

14 (1) ensure that patients using telemedicine medical
15 services receive appropriate, quality care;

16 (2) prevent abuse and fraud in the use of telemedicine
17 medical services, including rules relating to the filing of claims
18 and records required to be maintained in connection with
19 telemedicine medical services;

20 (3) ensure adequate supervision of health
21 professionals who are not physicians and who provide telemedicine
22 medical services;

23 (4) establish the maximum number of health
24 professionals who are not physicians that a physician may supervise
25 through a telemedicine medical service; and

26 (5) require a face-to-face consultation between a
27 patient and a physician providing a telemedicine medical service
28 within a certain number of days following an initial telemedicine
29 medical service only if the physician has never seen the patient.

30 (V.T.I.C. Art. 21.53F, Sec. 6(b), as added Acts 75th Leg., R.S.,
31 Ch. 880.)

32 Source Law

33 (b) The Texas State Board of Medical Examiners,
34 in consultation with the commissioner, as appropriate,
35 may adopt rules as necessary to:

36 (1) ensure that appropriate care,
37 including quality of care, is provided to patients who
38 receive telemedicine medical services;

39 (2) prevent abuse and fraud through use of
40 telemedicine medical services, including rules
41 relating to filing of claims and records required to be

1 maintained in connection with telemedicine medical
2 services;

3 (3) ensure adequate supervision of health
4 professionals who are not physicians and who provide
5 telemedicine medical services;

6 (4) establish the maximum number of health
7 professionals who are not physicians that a physician
8 may supervise through a telemedicine medical service;
9 and

10 (5) require a face-to-face consultation
11 between a patient and a physician providing a
12 telemedicine medical service within a certain number
13 of days following an initial telemedicine medical
14 service only if the physician has never seen the
15 patient.

16 SECTION 23. CONFORMING AMENDMENT. Subchapter B, Chapter
17 171, Tax Code, is amended by adding Section 171.0525 to read as
18 follows:

19 Sec. 171.0525. EXEMPTION--CERTAIN INSURANCE COMPANIES. A
20 corporation that is a farm mutual insurance company, local mutual
21 aid association, or burial association is exempted from the
22 franchise tax. (V.T.I.C. Art. 4.10, Sec. 14.)

23 Source Law

24 Sec. 14. Farm mutuals, local mutual aid
25 associations and burial associations are not subject
26 to the franchise tax.

27 Revisor's Note

28 Section 14, V.T.I.C. Article 4.10, exempts farm
29 mutual insurance companies, local mutual aid
30 associations, and burial associations from the
31 franchise tax. The revised law adds a reference to a
32 corporation that is a farm mutual insurance company,
33 local mutual aid association, or burial association
34 because only corporations are subject to the franchise
35 tax.

36 SECTION 24. CONFORMING AMENDMENT. Subchapter B, Chapter
37 171, Tax Code, is amended by adding Section 171.0527 to read as
38 follows:

39 Sec. 171.0527. EXEMPTION--TITLE INSURANCE COMPANIES AND
40 TITLE INSURANCE AGENTS. (a) In this section, "title insurance
41 company" and "title insurance agent" have the meanings assigned by
42 Section 2501.003, Insurance Code.

1 Article 21.49-1" of the Insurance Code. For purposes
2 of Section 16, the relevant terms defined in Article
3 21.49-1 and revised as Sections 823.002 and 823.151 of
4 the Insurance Code are "control," "controlled
5 insurer," "domestic insurer," and "holding company."
6 Also, the terms "title insurance," "title insurance
7 agent," and "title insurance company" as used in
8 Section 16 are defined in Article 9.02 of the Insurance
9 Code and revised in Section 2501.003 of the Insurance
10 Code. For the reader's convenience, the revised law
11 lists the relevant terms and includes a reference to
12 the sections of the revised law in which they are
13 defined.

14 Sec. 171.892. ELIGIBILITY. A corporation is entitled to a
15 credit as provided by this subchapter against the tax imposed under
16 this chapter if the corporation:

17 (1) is a title insurance holding company subject to
18 Chapter 823, Insurance Code; and

19 (2) controls one or more domestic title insurance
20 companies that are subject to the tax on premiums imposed under
21 Chapter 223, Insurance Code. (V.T.I.C. Art. 9.59, Sec. 16(b)
22 (part).)

23 Source Law

24 (b) A title insurance holding company that is
25 subject to Article 21.49-1, Insurance Code, and which
26 controls one or more domestic title insurance
27 companies that are subject to the tax on premiums under
28 this article is entitled to a credit against its
29 franchise tax imposed by Chapter 171, Tax Code. . . .

30 Revisor's Note

31 Section 16(b), V.T.I.C. Article 9.59, provides a
32 franchise tax credit for certain title insurance
33 holding companies. The revised law adds a reference to
34 a corporation that is a title insurance holding
35 company because only corporations are subject to the
36 franchise tax.

- 1 Legislature, Regular Session, 1997;
- 2 (3) 3.70-3C, as added by Chapter 1260, Acts of the 75th
3 Legislature, Regular Session, 1997;
- 4 (4) 20A.09, as amended by Chapters 163, 837, 905,
5 1023, and 1026, Acts of the 75th Legislature, Regular Session,
6 1997;
- 7 (5) 20A.09H, as redesignated and amended by Chapter
8 396, Acts of the 77th Legislature, Regular Session, 2001;
- 9 (6) 20A.09H, as redesignated and amended by Chapter
10 1027, Acts of the 77th Legislature, Regular Session, 2001;
- 11 (7) 20A.18D, as added by Chapter 550, Acts of the 77th
12 Legislature, Regular Session, 2001;
- 13 (8) 21.07-1, as added by Chapter 213, Acts of the 54th
14 Legislature, Regular Session, 1955;
- 15 (9) 21.07-1, as added by Chapter 703, Acts of the 77th
16 Legislature, Regular Session, 2001;
- 17 (10) 21.21-6, as added by Chapter 415, Acts of the 74th
18 Legislature, Regular Session, 1995;
- 19 (11) 21.21-6, as added by Chapter 522, Acts of the 74th
20 Legislature, Regular Session, 1995;
- 21 (12) 21.21-9, as added by Chapter 596, Acts of the 75th
22 Legislature, Regular Session, 1997;
- 23 (13) 21.21-9, as added by Chapter 1007, Acts of the
24 75th Legislature, Regular Session, 1997;
- 25 (14) 21.52G, as added by Chapter 725, Acts of the 75th
26 Legislature, Regular Session, 1997;
- 27 (15) 21.52G, as added by Chapter 955, Acts of the 75th
28 Legislature, Regular Session, 1997;
- 29 (16) 21.52L, as added by Chapter 1074, Acts of the 77th
30 Legislature, Regular Session, 2001;
- 31 (17) 21.52L, as added by Chapter 1106, Acts of the 77th
32 Legislature, Regular Session, 2001;
- 33 (18) 21.53D, as added by Chapter 912, Acts of the 75th
34 Legislature, Regular Session, 1997;

1 (19) 21.53D, as added by Chapter 1285, Acts of the 75th
2 Legislature, Regular Session, 1997;

3 (20) 21.53F, as added by Chapter 683, Acts of the 75th
4 Legislature, Regular Session, 1997;

5 (21) 21.53F, as added by Chapter 832, Acts of the 75th
6 Legislature, Regular Session, 1997;

7 (22) 21.53F, as added by Chapter 880, Acts of the 75th
8 Legislature, Regular Session, 1997; and

9 (23) 21.53F, as added by Chapter 1287, Acts of the 75th
10 Legislature, Regular Session, 1997.

11 (b) The following laws are repealed:

12 (1) Subsections (a), (c), and (d), Article 1.04D,
13 Insurance Code;

14 (2) Section 8, Article 1.14-3, Insurance Code;

15 (3) Subchapters J and K, Chapter 3, Insurance Code;

16 (4) Chapters 9, 24, 26, 27, 28A, and 28B, Insurance
17 Code;

18 (5) Subchapter F, Chapter 101, Insurance Code; and

19 (6) Article 9031, Revised Statutes.

20 SECTION 27. LEGISLATIVE INTENT. This Act is enacted under
21 Section 43, Article III, Texas Constitution. This Act is intended
22 as a recodification only, and no substantive change in law is
23 intended by this Act.

24 SECTION 28. EFFECTIVE DATE. This Act takes effect April 1,
25 2005.

1 APPENDIX B

2 CHAPTER 311. CODE CONSTRUCTION ACT

3 (current as of end of 78th Legislature, Regular Session, 2003)

4 SUBCHAPTER A. GENERAL PROVISIONS

5 Sec. 311.001. SHORT TITLE. This chapter may be cited as
6 the Code Construction Act.

7 Sec. 311.002. APPLICATION. This chapter applies to:

8 (1) each code enacted by the 60th or a subsequent
9 legislature as part of the state's continuing statutory revision
10 program;

11 (2) each amendment, repeal, revision, and reenactment
12 of a code or code provision by the 60th or a subsequent legislature;

13 (3) each repeal of a statute by a code; and

14 (4) each rule adopted under a code.

15 Sec. 311.003. RULES NOT EXCLUSIVE. The rules provided in
16 this chapter are not exclusive but are meant to describe and clarify
17 common situations in order to guide the preparation and
18 construction of codes.

19 Sec. 311.004. CITATION OF CODES. A code may be cited by its
20 name preceded by the specific part concerned. Examples of
21 citations are:

22 (1) Title 1, Business & Commerce Code;

23 (2) Chapter 5, Business & Commerce Code;

24 (3) Section 9.304, Business & Commerce Code;

25 (4) Section 15.06(a), Business & Commerce Code; and

26 (5) Section 17.18(b)(1)(B)(ii), Business & Commerce
27 Code.

28 Sec. 311.005. GENERAL DEFINITIONS. The following
29 definitions apply unless the statute or context in which the word or
30 phrase is used requires a different definition:

31 (1) "Oath" includes affirmation.

32 (2) "Person" includes corporation, organization,
33 government or governmental subdivision or agency, business trust,
34 estate, trust, partnership, association, and any other legal

1 entity.

2 (3) "Population" means the population shown by the
3 most recent federal decennial census.

4 (4) "Property" means real and personal property.

5 (5) "Rule" includes regulation.

6 (6) "Signed" includes any symbol executed or adopted
7 by a person with present intention to authenticate a writing.

8 (7) "State," when referring to a part of the United
9 States, includes any state, district, commonwealth, territory, and
10 insular possession of the United States and any area subject to the
11 legislative authority of the United States of America.

12 (8) "Swear" includes affirm.

13 (9) "United States" includes a department, bureau, or
14 other agency of the United States of America.

15 (10) "Week" means seven consecutive days.

16 (11) "Written" includes any representation of words,
17 letters, symbols, or figures.

18 (12) "Year" means 12 consecutive months.

19 (13) "Includes" and "including" are terms of
20 enlargement and not of limitation or exclusive enumeration, and use
21 of the terms does not create a presumption that components not
22 expressed are excluded.

23 Sec. 311.006. INTERNAL REFERENCES. In a code:

24 (1) a reference to a title, chapter, or section
25 without further identification is a reference to a title, chapter,
26 or section of the code; and

27 (2) a reference to a subtitle, subchapter, subsection,
28 subdivision, paragraph, or other numbered or lettered unit without
29 further identification is a reference to a unit of the next larger
30 unit of the code in which the reference appears.

31 SUBCHAPTER B. CONSTRUCTION OF WORDS AND PHRASES

32 Sec. 311.011. COMMON AND TECHNICAL USAGE OF WORDS. (a)
33 Words and phrases shall be read in context and construed according
34 to the rules of grammar and common usage.

1 (b) Words and phrases that have acquired a technical or
2 particular meaning, whether by legislative definition or
3 otherwise, shall be construed accordingly.

4 Sec. 311.012. TENSE, NUMBER, AND GENDER. (a) Words in the
5 present tense include the future tense.

6 (b) The singular includes the plural and the plural includes
7 the singular.

8 (c) Words of one gender include the other genders.

9 Sec. 311.013. AUTHORITY AND QUORUM OF PUBLIC BODY. (a) A
10 grant of authority to three or more persons as a public body confers
11 the authority on a majority of the number of members fixed by
12 statute.

13 (b) A quorum of a public body is a majority of the number of
14 members fixed by statute.

15 Sec. 311.014. COMPUTATION OF TIME. (a) In computing a
16 period of days, the first day is excluded and the last day is
17 included.

18 (b) If the last day of any period is a Saturday, Sunday, or
19 legal holiday, the period is extended to include the next day that
20 is not a Saturday, Sunday, or legal holiday.

21 (c) If a number of months is to be computed by counting the
22 months from a particular day, the period ends on the same numerical
23 day in the concluding month as the day of the month from which the
24 computation is begun, unless there are not that many days in the
25 concluding month, in which case the period ends on the last day of
26 that month.

27 Sec. 311.015. REFERENCE TO A SERIES. If a statute refers
28 to a series of numbers or letters, the first and last numbers or
29 letters are included.

30 Sec. 311.016. "MAY," "SHALL," "MUST," ETC. The following
31 constructions apply unless the context in which the word or phrase
32 appears necessarily requires a different construction or unless a
33 different construction is expressly provided by statute:

34 (1) "May" creates discretionary authority or grants

1 permission or a power.

2 (2) "Shall" imposes a duty.

3 (3) "Must" creates or recognizes a condition
4 precedent.

5 (4) "Is entitled to" creates or recognizes a right.

6 (5) "May not" imposes a prohibition and is synonymous
7 with "shall not."

8 (6) "Is not entitled to" negates a right.

9 (7) "Is not required to" negates a duty or condition
10 precedent.

11 SUBCHAPTER C. CONSTRUCTION OF STATUTES

12 Sec. 311.021. INTENTION IN ENACTMENT OF STATUTES. In
13 enacting a statute, it is presumed that:

14 (1) compliance with the constitutions of this state
15 and the United States is intended;

16 (2) the entire statute is intended to be effective;

17 (3) a just and reasonable result is intended;

18 (4) a result feasible of execution is intended; and

19 (5) public interest is favored over any private
20 interest.

21 Sec. 311.022. PROSPECTIVE OPERATION OF STATUTES. A
22 statute is presumed to be prospective in its operation unless
23 expressly made retrospective.

24 Sec. 311.023. STATUTE CONSTRUCTION AIDS. In construing a
25 statute, whether or not the statute is considered ambiguous on its
26 face, a court may consider among other matters the:

27 (1) object sought to be attained;

28 (2) circumstances under which the statute was enacted;

29 (3) legislative history;

30 (4) common law or former statutory provisions,
31 including laws on the same or similar subjects;

32 (5) consequences of a particular construction;

33 (6) administrative construction of the statute; and

34 (7) title (caption), preamble, and emergency

1 provision.

2 Sec. 311.024. HEADINGS. The heading of a title, subtitle,
3 chapter, subchapter, or section does not limit or expand the
4 meaning of a statute.

5 Sec. 311.025. IRRECONCILABLE STATUTES AND AMENDMENTS. (a)
6 Except as provided by Section 311.031(d), if statutes enacted at
7 the same or different sessions of the legislature are
8 irreconcilable, the statute latest in date of enactment prevails.

9 (b) Except as provided by Section 311.031(d), if amendments
10 to the same statute are enacted at the same session of the
11 legislature, one amendment without reference to another, the
12 amendments shall be harmonized, if possible, so that effect may be
13 given to each. If the amendments are irreconcilable, the latest in
14 date of enactment prevails.

15 (c) In determining whether amendments are irreconcilable,
16 text that is reenacted because of the requirement of Article III,
17 Section 36, of the Texas Constitution is not considered to be
18 irreconcilable with additions or omissions in the same text made by
19 another amendment. Unless clearly indicated to the contrary, an
20 amendment that reenacts text in compliance with that constitutional
21 requirement does not indicate legislative intent that the reenacted
22 text prevail over changes in the same text made by another
23 amendment, regardless of the relative dates of enactment.

24 (d) In this section, the date of enactment is the date on
25 which the last legislative vote is taken on the bill enacting the
26 statute.

27 (e) If the journals or other legislative records fail to
28 disclose which of two or more bills in conflict is latest in date of
29 enactment, the date of enactment of the respective bills is
30 considered to be, in order of priority:

31 (1) the date on which the last presiding officer
32 signed the bill;

33 (2) the date on which the governor signed the bill; or

34 (3) the date on which the bill became law by operation

1 of law.

2 Sec. 311.026. SPECIAL OR LOCAL PROVISION PREVAILS OVER
3 GENERAL. (a) If a general provision conflicts with a special or
4 local provision, the provisions shall be construed, if possible, so
5 that effect is given to both.

6 (b) If the conflict between the general provision and the
7 special or local provision is irreconcilable, the special or local
8 provision prevails as an exception to the general provision, unless
9 the general provision is the later enactment and the manifest
10 intent is that the general provision prevail.

11 Sec. 311.027. STATUTORY REFERENCES. Unless expressly
12 provided otherwise, a reference to any portion of a statute or rule
13 applies to all reenactments, revisions, or amendments of the
14 statute or rule.

15 Sec. 311.028. UNIFORM CONSTRUCTION OF UNIFORM ACTS. A
16 uniform act included in a code shall be construed to effect its
17 general purpose to make uniform the law of those states that enact
18 it.

19 Sec. 311.029. ENROLLED BILL CONTROLS. If the language of
20 the enrolled bill version of a statute conflicts with the language
21 of any subsequent printing or reprinting of the statute, the
22 language of the enrolled bill version controls.

23 Sec. 311.030. REPEAL OF REPEALING STATUTE. The repeal of a
24 repealing statute does not revive the statute originally repealed
25 nor impair the effect of any saving provision in it.

26 Sec. 311.031. SAVING PROVISIONS. (a) Except as provided
27 by Subsection (b), the reenactment, revision, amendment, or repeal
28 of a statute does not affect:

29 (1) the prior operation of the statute or any prior
30 action taken under it;

31 (2) any validation, cure, right, privilege,
32 obligation, or liability previously acquired, accrued, accorded,
33 or incurred under it;

34 (3) any violation of the statute or any penalty,

1 forfeiture, or punishment incurred under the statute before its
2 amendment or repeal; or

3 (4) any investigation, proceeding, or remedy
4 concerning any privilege, obligation, liability, penalty,
5 forfeiture, or punishment; and the investigation, proceeding, or
6 remedy may be instituted, continued, or enforced, and the penalty,
7 forfeiture, or punishment imposed, as if the statute had not been
8 repealed or amended.

9 (b) If the penalty, forfeiture, or punishment for any
10 offense is reduced by a reenactment, revision, or amendment of a
11 statute, the penalty, forfeiture, or punishment, if not already
12 imposed, shall be imposed according to the statute as amended.

13 (c) The repeal of a statute by a code does not affect an
14 amendment, revision, or reenactment of the statute by the same
15 legislature that enacted the code. The amendment, revision, or
16 reenactment is preserved and given effect as part of the code
17 provision that revised the statute so amended, revised, or
18 reenacted.

19 (d) If any provision of a code conflicts with a statute
20 enacted by the same legislature that enacted the code, the statute
21 controls.

22 Sec. 311.032. SEVERABILITY OF STATUTES. (a) If any
23 statute contains a provision for severability, that provision
24 prevails in interpreting that statute.

25 (b) If any statute contains a provision for
26 nonseverability, that provision prevails in interpreting that
27 statute.

28 (c) In a statute that does not contain a provision for
29 severability or nonseverability, if any provision of the statute or
30 its application to any person or circumstance is held invalid, the
31 invalidity does not affect other provisions or applications of the
32 statute that can be given effect without the invalid provision or
33 application, and to this end the provisions of the statute are
34 severable.

1 Sec. 311.034. WAIVER OF SOVEREIGN IMMUNITY. In order to
2 preserve the legislature's interest in managing state fiscal
3 matters through the appropriations process, a statute shall not be
4 construed as a waiver of sovereign immunity unless the waiver is
5 effected by clear and unambiguous language. In a statute, the use
6 of "person," as defined by Section 311.005 to include governmental
7 entities, does not indicate legislative intent to waive sovereign
8 immunity unless the context of the statute indicates no other
9 reasonable construction.

APPENDIX C
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46	26.43,	Subsec. (a)	1501.258
47		Subsec. (b)	1501.260
48		Subsec. (c)	1501.260
49		Subsec. (d)	1501.260
50		Subsec. (e)	1501.260
51		Subsec. (f)	1501.260
52		Subsec. (g)	1501.260
53	26.44	1501.259
54	26.44A,	Subsec. (a) (part)	1501.253
55		(part)	1501.258
56		Subsec. (b)	1501.253
57		Subsec. (c)	1501.253
58		Subsec. (d)	1501.253
59	26.44B	1501.254
60	26.48	1501.255
61	26.49,	Subsec. (a)	1501.102
62		Subsec. (b)	1501.102
63		Subsec. (c)	1501.103
64		Subsec. (d)	1501.103
65		Subsec. (e)	1501.102
66		Subsec. (f)	1501.102
67		Subsec. (g)	1501.104
68		Subsec. (h)	1501.105

1		Subsec. (j)	. . . . .	1501.606
2		Subsec. (k)	. . . . .	1501.606
3		Subsec. (l)	. . . . .	1501.603
4		Subsec. (m)	. . . . .	1501.106
5	26.84,	Subsec. (a)	. . . . .	1501.607
6		Subsec. (b)	. . . . .	1501.608
7		Subsec. (c)	. . . . .	1501.608
8		Subsec. (d)	. . . . .	1501.608
9		Subsec. (e)	. . . . .	1501.609
10	26.85	. . . . .	. . . . .	1501.101
11	26.86	. . . . .	. . . . .	1501.108
12	26.87	. . . . .	. . . . .	1501.109
13	26.88	. . . . .	. . . . .	1501.110
14	26.89,	Subsec. (a)	. . . . .	1501.610
15		Subsec. (b)	. . . . .	1501.107
16	26.90,	Subsec. (a)	. . . . .	1501.102
17		Subsec. (b)	. . . . .	1501.102
18		Subsec. (c)	. . . . .	1501.103
19		Subsec. (d)	. . . . .	1501.103
20		Subsec. (e)	. . . . .	1501.102
21		Subsec. (f)	. . . . .	1501.102
22		Subsec. (g)	. . . . .	1501.104
23		Subsec. (h)	. . . . .	1501.105
24	26.91,	Subsec. (a)	. . . . .	1501.611
25		Subsec. (b)	. . . . .	1501.615
26	26.92	. . . . .	. . . . .	1501.612
27	26.93	. . . . .	. . . . .	1501.613
28	26.94	. . . . .	. . . . .	1501.111
29	26.95	. . . . .	. . . . .	1501.616
30	26.96	. . . . .	. . . . .	1501.614
31	27.01	. . . . .	. . . . . RN	1502.001
32	27.02	. . . . .	. . . . .	1502.001
33	27.03	. . . . .	. . . . .	1502.051
34	27.04	. . . . .	. . . . .	1502.052
35	27.05	. . . . .	. . . . .	1502.053
36	27.06	. . . . .	. . . . .	1502.002
37	28A.01	. . . . .	. . . . .	601.001
38	28A.02	. . . . .	. . . . .	601.002
39	28A.03	. . . . .	. . . . .	601.003
40	28A.04	. . . . .	. . . . .	601.004
41	28A.51	. . . . .	. . . . .	601.051
42	28A.52	. . . . .	. . . . .	601.052
43	28A.101	. . . . .	. . . . .	601.101
44	28A.102	. . . . .	. . . . .	601.102
45	28B.01	. . . . .	. . . . .	602.001
46	28B.02	. . . . .	. . . . .	602.051
47	28B.03	. . . . .	. . . . .	602.052
48	28B.04	. . . . .	. . . . .	602.053
49	28B.05	. . . . .	. . . . .	602.002
50	28B.06	. . . . .	. . . . .	602.003
51	28B.07	. . . . .	. . . . .	602.101
52	28B.08	. . . . .	. . . . .	602.004
53	28B.09,	Sec. (a)	. . . . .	602.102
54		Sec. (b)	. . . . .	602.103
55		Sec. (c)	. . . . .	602.103
56		Sec. (d)	. . . . .	602.103
57	28B.10	. . . . .	. . . . .	602.104
58	28B.11	. . . . .	. . . . .	602.105
59	28B.12	. . . . .	. . . . .	602.106
60	101.251(a)	. . . . .	. . . . .	226.001
61		(b) (part)	. . . . .	226.002
62		(part)	. . . . .	226.003
63		(part)	. . . . .	226.005
64		(c)	. . . . .	226.003
65		(d)	. . . . .	226.003
66		(e)	. . . . .	226.003
67		(f)	. . . . .	226.003
68		(g)	. . . . .	226.005

1	(h)	. . . . .	226.004
2	(i)	. . . . .	226.005
3	(j)	. . . . .	226.003
4	101.252(a)	. . . . .	226.051
5	(b)	(part)	226.052
6		(part)	226.053
7		(part)	226.054
8	(c)	226.053
9	(d)	226.054
10	(e)	226.054
11	(f)	226.056
12	(g)	226.053
13	101.253	226.055
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15	9031, Sec. 1	557.051
16	Sec. 2	557.052